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Tennessee Medicine

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IN THIS ISSUE

• TMA takes action to eliminate the use of gag rules by managed care plans
153

• A sign of things to come? Read about Memphis' growing integrated delivery systems
155

• Grading TennCare: Drs. Chang and Mirvis take a close look at the fledgling program
159



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President's Comments

- 149 Strong as Oaks

Editorials

- 150 A New Look
151 Foxy in the Henhouse
152 Impairment Ratings

Medicine and Law

- 153 It's Time To Take Off the Gag—TMA Takes Progressive Action To Head Off Managed Care Gag Rules—*Betsy Kauffman Humphrey*

Practicing Medicine

- 155 Building for the Future—Memphis Integrated Delivery Systems May Provide a Glimpse of the Future for Tennessee Doctors—*Tim Sewell*
158 Grading TennCare—*Cyril F. Chang, PhD; David M. Mirvis, MD*
161 Loss Prevention Case of the Month—Complication During Arthroscopy—*J. Kelley Avery, MD*

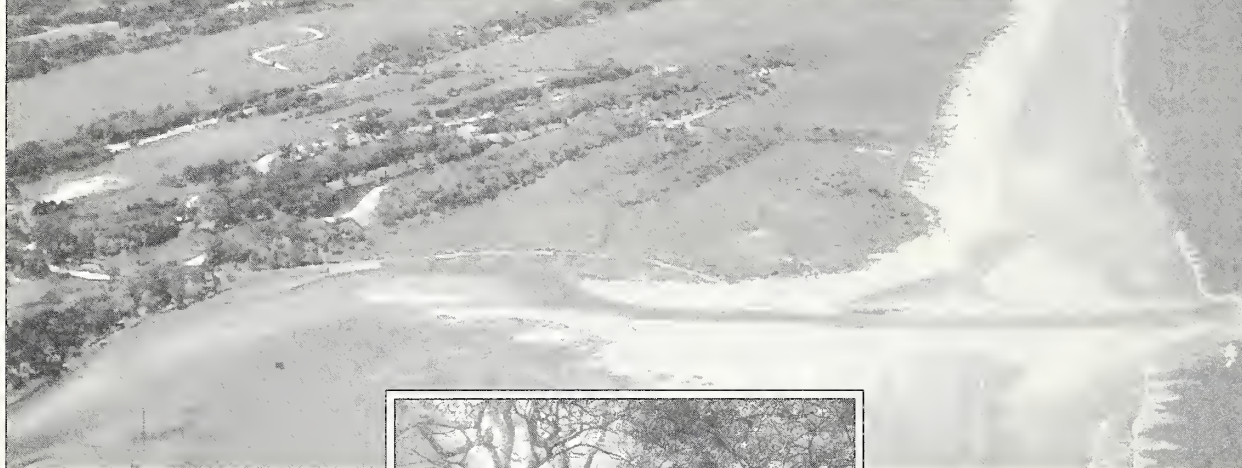
The Journal

- 164 Original Contribution—Diagnosis of Meckel's Diverticulum by Computerized Tomography—*Robert W. Ikard, MD*
166 Vanderbilt Morning Report—Antiphospholipid and Anticentromere Antibodies Occurring Together in a Patient With Pulmonary Hypertension
167 Trauma Rounds—An Abdominal Hernia Secondary to Blunt Trauma
169 Department of Health Report—Project TEACH in the School System

News and Views

- 171 Letters to the Editor—Disability Evaluations
171 TMA Alliance Report—A Year of Firsts
171 In Memoriam
171 New Members
172 Personal News
172 PRA Recipients
172 Actions of the Tennessee Board of Medical Examiners
173 Special Communication—Management of Prescribing With Emphasis on Addictive or Dependence-Producing Drugs (Tennessee Board of Medical Examiners Policy Statement)
174 Continuing Medical Education Opportunities
177 Career Opportunity Advertising
178 Information for Authors
178 Advertisers in this Issue

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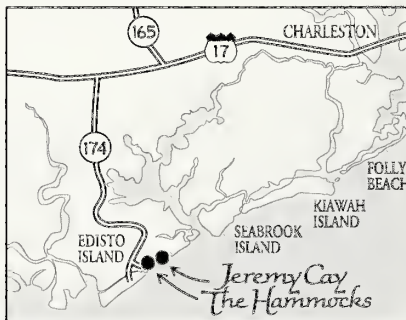


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Table of Contents

President's Comments

- 185 A Paradigm for Healing

Editorials

- 187 Tennessee Bicentennial
188 Hello, Choir! Are You Listening?
189 Some Happy Thoughts

Practicing Medicine

- 191 Managed Care: Are Restrictive Provider Panels Out and Capitation In?—
Mo Kirtane

Abstract of TMA's 161st Annual Meeting

- 193 Index to Proceedings
194 House of Delegates Proceedings
206 Reports of Officers
211 Annual Award Presentations
215 Photographic Highlights of the Annual Meeting
216 House of Delegates Composition

News and Views

- 217 In Memoriam
217 New Members
217 Personal News
218 PRA Recipients
218 Actions of the Tennessee Board of Medical Examiners
218 Continuing Medical Education Opportunities
222 Career Opportunity Advertising

ON THE COVER

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Table of Contents

President's Comments

- 229 At the Front—*Richard M. Pearson, MD*

Editorials

- 231 On Providing and Consuming—*John B. Thomison, MD*
232 The Saga of Sunny: A Bicentennial Tail for the Fourth—*John B. Thomison, MD*
233 The Once and Future Annual Meeting—*John B. Thomison, MD*
235 To Be or Not To Be . . . That Was Just One of the Questions—*Russ Miller*

Medicine and Politics

- 239 TennCare BHOs—Partners Program Startup Mirrors TennCare; Mental Health Patients Lumped Into Two Plans—*Liz Murray Garrigan*

Practicing Medicine

- 241 Where Did All the Specialties Go? Managed Care Trends Steer Tomorrow's MDs Into Primary Care Slots—*Tim Sewell*
244 Loss Prevention Case of the Month—Difficult Diagnosis—*J. Kelley Avery, MD*

The Journal

- 247 Original Contribution—Cardiac Tamponade as the Initial Presentation of Bronchioloalveolar Cell Carcinoma—*Joseph Hourany, MD; Ryland P. Byrd Jr., MD; Thomas M. Roy, MD*
249 Trauma Rounds—Repair of Penetrating Cardiac Injury Using Skin Staples
252 Vanderbilt Morning Report—A Diabetic Man With Left Shoulder Pain
254 Department of Health Report—Post-Exposure Immunoprophylaxis and Chemoprophylaxis for Communicable Diseases

TMA Organizational

- 260 Highlights of the TMA Board of Trustees Meetings—April 11 and 14, 1996
261 TMA Leadership 1996-1997
262 Component Society Officers 1996-1997

News and Views

- 257 TMA Alliance Report—Yes, We Can!
257 In Memoriam
257 New Members
257 Personal News
258 Actions of the Tennessee Board of Medical Examiners
259 PRA Recipients
259 Continuing Medical Education Opportunities
265 Career Opportunity Advertising
266 Information for Authors
266 Advertisers in this Issue

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President's Comments

- 273 **First Names**—*Richard M. Pearson, MD*

Editorials

- 275 **Telemedicine**—*John B. Thomison, MD*
276 **Eldercare**—*John B. Thomison, MD*
278 **Safety First—Mostly**—*John B. Thomison, MD*

Practicing Medicine

- 282 **Telemedicine—Physicians Using Latest Technology To Help Patients**—*Joe Hall*
284 **Heri, Hodie, Cras . . . Yesterday, Today, and Tomorrow**—*Louis A. Cancellaro, MD, PhD*
286 **Loss Prevention Case of the Month—Who/Where is My Doctor?**—*J. Kelley Avery, MD*

The Journal

- 289 **Original Contribution**—*Cat Scratch Disease Presenting as Multifocal Osteitis*—*Gail Gallemlere, MD; Kim Worley, MS-III*
291 **Trauma Rounds**—*Care of the Geriatric Trauma Patient*—*Sherry M. Melton, MD; Joe H. Patton Jr., MD; Sean P. Lyden, MD; Martin A. Croce, MD*
294 **Vanderbilt Morning Report**—*A Potentially Fatal Drug Reaction*—*Deepa Patel, MD; Francis J. Caprio, MD*
296 **Preventive Medicine Series**—*Avoiding Problems Prescribing to Older Patients*—*Rebecca J. Beyth, MD; Ronald I. Shorr, MD, MS*
299 **Department of Health Report**—*Tobacco Use: Tennessee Youths at Risk*—*Cornelia M. Pearson, RN, MN*

News and Views

- 302 **TMA Alliance Report**—*Handrails for Membership*—*Peggy Larkin*
302 **PRA Recipients**
302 **In Memoriam**
302 **New Members**
303 **Personal News**
303 **Actions of the Tennessee Board of Medical Examiners**
303 **Continuing Medical Education Opportunities**
305 **Career Opportunity Advertising**
306 **Information for Authors**
306 **Advertisers in this Issue**

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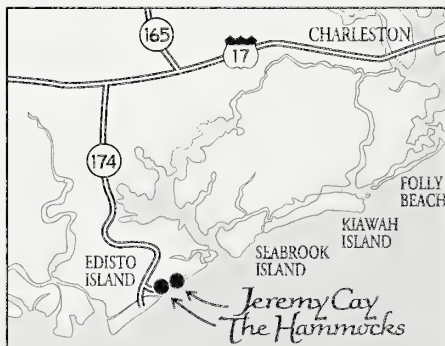
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President's Comments

- 313 Energy Enough—*Richard M. Pearson, MD*

Editorials

- 315 Federation Mediation Meditation—Or Hesitation? Trepidation?—*John B. Thomison, MD*
316 Celebration of a Life: Tommy Ballard, R.I.P.—*John B. Thomison, MD*

Practicing Medicine

- 319 Overhauling the Federation of Medicine—*Tim Sewell*
322 Loss Prevention Case of the Month—Postpartum Back Pain, So What!—*J. Kelley Avery, MD*

Medicine and Politics

- 324 '96 Election—Every Vote Counts

The Journal

- 328 Original Contribution—Catheter-Associated Central Venous Thrombosis—*Ryland P. Byrd Jr., MD; Robert W. Lukeman, MD; Mathew Mathai, MD; M. K. Mathew, MD*
330 Department of Health Report—Office of Rural Health: Forging the Future of Rural Health Recruitment and Retention—*Bill Jolley, MPA*
333 Special Communication—Stroke Prevention: Recommendations
335 Trauma Rounds—Management of the Pregnant Patient With Acute Spinal Cord Injury—*Craig R. Nunn, MD; John G. Bass, BA; Virginia A. Eddy, MD*
338 Vanderbilt Morning Report—Low Back Pain With Progressive Weakness: A Case of Cauda Equina Syndrome From Lumbar Disc Herniation—*Anderson Spickard III, MD; Jeannine Z. P. Engel, MD;*

News and Views

- 341 TMA Alliance Report—Accomplishments of a Healthy Organization
341 Letter to the Editor—There Are Better Ways To Help These Children
342 In Memoriam
342 New Members
342 Actions of the Tennessee Board of Medical Examiners
342 PRA Recipients
343 Continuing Medical Education Opportunities
345 Career Opportunity Advertising
346 Information for Authors
346 Advertisers in this Issue



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Table of Contents

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President's Comments

- 353 Emperors and Empires—*Richard M. Pearson, MD*

Editorials

- 355 Stroke—*John B. Thomison, MD*
355 IMPACT!!!—*John B. Thomison, MD*
356 Med School Revisited: 1941 to '44—And so on to 1996 and Beyond—*John B. Thomison, MD*

Practicing Medicine

- 359 Students: Fulfilling the Dream—*Tim Sewell*
363 Loss Prevention Case of the Month—Postoperative Delay—*J. Kelley Avery, MD*

Medicine and Technology

- 365 Patient Information on the Internet—*Irish Bahan*

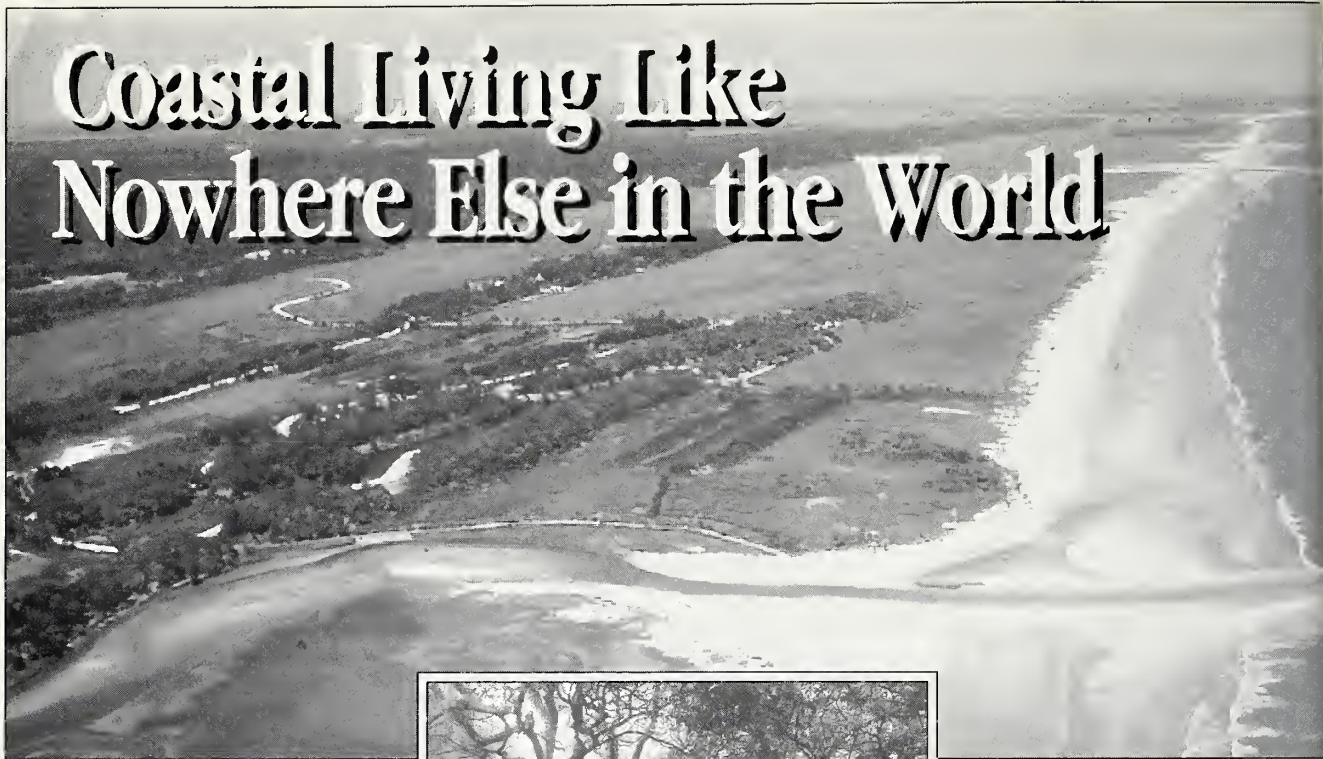
The Journal

- 369 Original Contribution—Nutritional Status and Mortality in Respiratory Failure Caused by Tuberculosis—*Jay B. Mehta, MD; Cheryl L. Fields, MD; Ryland P. Byrd Jr., MD; Thomas M. Roy, MD*
372 Trauma Rounds—Traumatic Pseudocyst of the Spleen—*Jonathan D. Woody, MD; Phillip R. Craft, MD; Thaddeus S. Fabian, MD; Lewis B. Somberg, MD*
374 Stroke Prevention Series—Medical Revolution: The Prevention and Treatment of Stroke, 1996. Part 1. Stroke Prevention and Carotid Endarterectomy—*Howard S. Kirshner, M.D.*
376 Vanderbilt Morning Report—Shortness of Breath and Chest Pain in a Patient With Scleroderma—*Jeannine Z. P. Engel, MD*
378 Department of Health Report—Preventing Traumatic Brain Injury—*Jean Doster, MS*

News and Views

- 381 TMA Alliance Report—Dollars Can Make an Impact; Goals 1996—Why We Matter
381 Letter to the Editor—Loss Prevention; Response
382 Highlights of the TMA Board of Trustees Meeting—July 13-14, 1996
383 PRA Recipients
383 In Memoriam
383 New Members
384 Personal News
384 Continuing Medical Education Opportunities
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386 Information for Authors
386 Advertisers in this Issue

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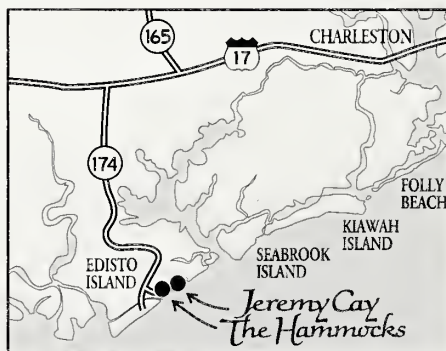


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President's Comments

- 395 Thank You—*Richard M. Pearson, MD*

Editorials

- 397 HMOs—The Latest Revisitation—*John B. Thomison, MD*

- 397 Thanksgiving—*John B. Thomison, MD*

Practicing Medicine

- 399 Teaming Up With UT Football—TMA's 1996 Radio Campaign—*Russ Miller*

- 400 Loss Prevention Case of the Month—Negligence in a Good Practice—*J. Kelley Avery, MD*

Medicine and Politics

- 402 Campaigning in Cyberspace

Medicine and Law

- 403 Crossing a Patient's Sexual Boundaries—*Marc E. Overlock; Robert J. Gonzales*

The Journal

- 407 Original Contribution—Comparison of Female and Male Graduates of Southern Appalachian Family Practice Residencies—*Jo Ann Rosenfeld, MD; P.M. Zaborlik, PhD*

- 410 Stroke Prevention Series—Medical Revolution: The Prevention and Treatment of Stroke, 1996. Part 2. Medical Prevention of Stroke and Acute Stroke Therapy—*Howard S. Kirshner, MD*

- 413 Trauma Rounds—Nonoperative Management of a Blunt Pancreatic Injury—*John R. Hall, MD; Paul Crawford, MD; James V. Lewis, MD*

- 415 Department of Health Report—Preventing Childhood Lead Poisoning in Tennessee—*Mary Yarbrough, MD, MPH; Marilyn Holmes, MS, RD, LDN*

- 417 Vanderbilt Morning Report—Progressive Somnolence and Confusion in a Patient With Hereditary Hemorrhagic Telangiectasias—*Taraz Samandari, MD; Brian D. Smith, MD*

News and Views

- 420 TMA Alliance Report—AMA-ERF

- 421 Letter to the Editor—Tobacco Abuse

- 421 PRA Recipients

- 421 In Memoriam

- 421 New Members

- 422 Personal News

- 422 Continuing Medical Education Opportunities

- 425 Career Opportunity Advertising

- 426 Information for Authors

- 426 Advertisers in this Issue

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Table of Contents

President's Comments

- 433 Stand Fast—*Richard M. Pearson, MD*

Editorials

- 435 Scouting for Zebras—*John B. Thomison, MD*
436 For Each New Sunrise . . .—*John B. Thomison, MD*

Practicing Medicine

- 438 HMO Preparedness—*Know Your Practice Inside and Out—Irish Bahan*
440 Loss Prevention Case of the Month—*Did Socioeconomic Factors Influence Clinical Decisions?—J. Kelley Avery, MD*

Medicine and Law

- 442 AMA Fights for Physician Antitrust Relief—*Department of Justice and FTC Redefine Antitrust Rules—Tim Sewell*

The Journal

- 447 Original Contribution—*Recognizing Weber-Christian Disease—Ghazali A. Khan, MD; Frances I. Lewis, MD*
450 Department of Health Report—*Newborn Screening in Tennessee—H. Lee Fleshood, PhD, MPA*
451 Stroke Prevention Series—*Acute Stroke Intervention—Kenneth J. Gaines, MD*

TMA Organizational

- 458 Tennessee Medicine—*Index to Volume 89*

News and Views

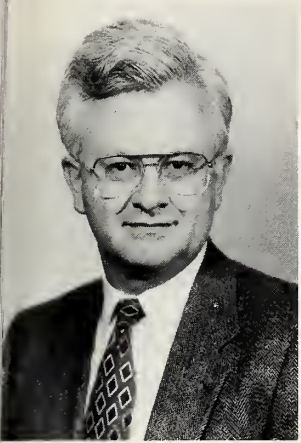
- 462 TMA Alliance Report—*Youth Health Workshop '96*
462 In Memoriam
462 New Members
463 Actions of the Tennessee Board of Medical Examiners
463 PRA Recipients
463 Continuing Medical Education Opportunities
465 Career Opportunity Advertising
466 Information for Authors
466 Advertisers in this Issue

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Richard M. Pearson, MD

Strong as Oaks

Who are we? In modern medical practice, this is increasingly a pragmatic, and not a philosophical, question. We are called "providers," "caregivers," "gatekeepers," "subspecialists," "directors," and "health maintenance personnel." We are referred to as "obstructionist," "status quo," "shortsighted," "not business-like," and "reluctant."

Abraham Lincoln once proposed this question: If you call a tail a leg, how many legs does a dog have? The answer, according to Abe, is "four"—calling a tail a leg does not make it a leg. We, my colleagues, are what we are, not what we are called.

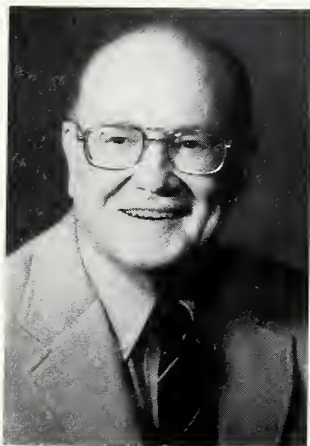
What do you call the tree that grows from an acorn? "Great oaks from tiny acorns grow." The acorn first roots itself in the soil of past oak leaves, then grows to great heights. The oak tree as it grows must continuously strengthen its bonds to the earth in order to survive and progress. Similarly we physicians must constantly strengthen that which holds us to humanity—our ethical bonds.

As physicians we live in two spheres: the one being the accumulated wealth of medical knowledge, tradition, and principle, and the other being the seeming chaos of our current professional lives. What binds the two together, what ties the present to the past, what makes us professionals and not tradesmen, are our medical ethics.

We are all leaves on the oak of medicine. Our professional lives vary greatly by personality, location, specialty, and circumstance. But we all experience sunlight, and rain, and wind. Through it all we must cling to the tree by professional conduct, nourish its roots, strengthen its fiber, and preserve medicine for those we serve and for those who follow us. Stephen Covey reminds us: "Even in the midst of people or circumstances that seem to ignore the principles, we can be secure in the knowledge that principles are bigger than people or circumstances, and that thousands of years of history have seen them triumph, time and time again."

Our pride in our profession must be born and nurtured in humility: we serve the sick, not ourselves, not government, not business. If we serve well, we enjoy the infinite rewards of humble service to others.

Who are we? My answer is "We are physicians in the great tradition. Our predecessors and mentors were physicians, and those who follow us must be physicians. We have a sacred duty to preserve a sacred profession. If we do less, we are nothing. We cannot do more." □



John B. Thomison, MD

A New Look

Tell me not, in mournful numbers,
Life is but an empty dream!—
For the soul is dead that slumbers,
And things are not what they seem.

Henry W. Longfellow
"A Psalm of Life"

If you are in a hurry and want to escape some of my deathless prose that leads up to the meat of the message, you can skip the next couple of paragraphs and go to a short one that summarizes what the long ones say. Of course, if you do that you'll never know the reason for the above quotation. Then again, maybe you don't care. So be my guest and skip away, if you wish. It's your loss. But maybe you can stand it.

As I have been telling you for some months now, things at TMA, which includes the *Journal*, are a'changin'. Or at least so it would seem. I myself am not certain to what extent that is so, and that also includes the *Journal*. It's not that I am being deliberately kept in the dark, since I have been in it from its inception, or at least since the Board got the notion of trying to make the Association more responsive to the needs of its membership. It's just that despite our good (we hope) intentions there are forces operating beyond the powers of any of us to control or to predict. As with most things these days, the magic word is m*o*n*e*y. Before we can spend it we have to have it, and to have it, we have somehow to get it. Getting it depends upon the interaction of two separate functions: the efficacy of the getters (us) and the—I started to say gullibility, but let's make it pliability, instead—of the sources. So there won't be any misunderstanding as to definitions, the sources I have in mind here are advertisers and not our members, who are indeed our major source of funds, but not the source we are attempting to massage—at least not now. If this sounds brazen and mercenary, it's because it is, and that's the way it is because that is unfortunately the way the world turns these days. (If you think "these" days are different in that respect from "those" days, I have news for you. It's just that in those days the process seems to have been more refined, though that doesn't mean necessarily they were. Things aren't always what they seem. And anyway, a better word than more refined might be "better concealed.")

Which brings me to the quotation that heads this piece. First, let me say I've never been quite able to catch the drift of that quotation, except that I *do* know what the last line means, and that's why I used it. I'm sure Mr. Longfellow, who was a great poet and philosopher, must have had something definite in mind, though there is in fact another possibility, even though it takes some not inconsiderable temerity to mention it. The other possibility is that he just put it there for no better reason than that it sounded good to him for openers. That is called poetic license. Poets can get away with it where nobody else can. It must have sounded good to my distinguished English professor, Dr. Eddie Mims, too, since he insisted that we learn it, though not, of course, just that stanza. It belongs to, and in fact opens, a fairly long and sometimes windy poem, filled with glorious exhortation. Its subtitle is "What the Heart of the Young Man Said to the Psalmist." That is not very enlightening to me, because the psalmist (actually, psalmists, and Mr. Longfellow didn't tell us which one) said a lot of

things, some of them actually not too far removed from the thesis of this psalm of life. In any case, that last line simply reinforces my contention that one time is not all that different from another except on the surface. The Victorian period was less plainspoken than the present day, in that, for instance, scatology in mixed company was considered bad form, and had the potential of precipitating duels. This does not mean necessarily that society is, as has been suggested, more honest nowadays—only more open. The merits of that, as I'm sure you must be aware, have been and continue to be subject to a running and occasionally acrimonious debate.

In case you heeded my opening warning and just tuned in, all I have really said so far is that the *Journal* has, as any fool can plainly see (to quote Li'l Abner: "Ah kin see it!") a new look. Whether or not that means things are really different now remains to be seen, because things aren't always what they seem. That may merely be perception and not reality. Any change, real or otherwise, also may or may not be for the better. That also remains to be seen. I sincerely hope any debate about that will not turn acrimonious, and if it does won't involve me more than tangentially.

You will note that the *Journal* now carries some non-medical features. This is at the behest of our membership, which is after all what keeps us afloat. Russ Miller, who staffs communications and membership for our Association, has taken on such features as a project, and has worked hard at procuring suitable copy. If you approve his efforts, by all means let us know. If you think this not a proper function of the *Journal*, let us know that too. If you take that position, though, please be advised of two things: First, in a sense I am on your side, since one could say that by publishing such material, we have become neither fish nor fowl, and I find such an anomalous position disquieting. Secondly, though, better a live anomalous bastard than a dead purist—I think. And so we have taken the pragmatic approach to what we hope will enhance our chances of survival.

I anticipate survival of us both (the *Journal* and me, that is), and that I shall learn to like its new format. It's like getting old. It may not be all that Robert Browning predicted from his wisdom of 26 years, but it sure beats the alternative. I do, in fact, *expect* the survival of *Tennessee Medicine*, which in case you haven't noticed, is the *Journal's* new handle. I give its survival an edge over that of Tennessee medicine as we have known it, and only hope for the sake of us all that doesn't turn out to be damning it with faint praise.

Talk to us! In the end, we depend on you, since, to borrow a motto from WDCN, Nashville's PBS channel, You Make It Happen!

Foxy in the Henhouse

Sent by his mama to scrounge supper, a young scrounger in the chicken house managed to initiate a commotion among the scroungees, causing lights to flash on and the farmer to appear brandishing a shotgun. "Who's there?" he shouted. Teeth chattering, and at his wits' end, the boy whimpered, "Ain' nobody here but jes us chickens!" Likely more generic than apocryphal, the story with minor variations has been reenacted in myriads of venues the world, maybe even the universe, over since time immemorial. Ever so slightly rephrased, it is even not unlikely to have been the snake's response to God in the garden.

Two articles published elsewhere in this issue of the *Journal* speak clearly to the dilemma facing doctors who are being put, or worse, putting themselves, in the position of foxes in charge of the henhouse. One of the papers, entitled "It's Time To Take Off the Gag," has to do with regulatory and legislative efforts afoot to prohibit the inclusion of "gag" rules in contracts of doctors with HMOs and MCOs, rules that would prevent doctors discussing with their patients alternatives available elsewhere, or the presence of arrangements between the doctors and the organizations that would prove deleterious to their patients' welfare. The

other article has to do with health care delivery systems now in place between Memphis doctors and the hospitals in which they practice, and which are developing elsewhere in the state. That the title is "Building for the Future: Memphis Integrated Delivery Systems Provide a Glimpse of the Future for Tennessee Doctors" correctly implies that such systems are more than a trend. Like kudzu, they are engulfing everything in their path.

In the best of all possible worlds, these integrated delivery systems (IDS) would be an ideal practice situation. They would ensure high-quality cost-effective medical care, assuming that the two terms are not mutually exclusive, which in a sense they must be in that cost effectiveness implies that there are procedures or items that, even though they might be life-saving, are simply too expensive in a given situation. In short, medical care must be rationed. Implicit in the arrangement is that the treatment of choice must be the doctor's decision, and that if his pattern of care becomes too expensive, he will be removed from the system. In short, care must be of high quality, else his pattern of less than high quality care terminates him, but not of *too* high quality, else it is his economics that do him in.

Quoting Dr. Ron Lawson, vice-president of Medical Affairs for Methodist Hospitals of Memphis, "The systems will be cost-driven in the foreseeable future, so doctors who can't practice cost-efficient medicine will be the ones to suffer. It comes back to efficiency of practice. It comes down to what we measure—cost, and *later quality*, of care." (Emphasis mine.) 'Nuff said!

In the IDS, the doctor accepts with the hospital a share in the financial risk of caring for patients. In accepting that share of the risk, the doctor becomes a fox in charge of the henhouse. From that point on, there is a conflict of interest that cannot be escaped or denied, and the patient will have lost the last vestige of an unbiased advocate. Never think that you and the hospital are equal partners. Hospitals are simply places where care is rendered. The hospital is not responsible for the patient's care. *You* are, Doctor—morally, ethically, and legally. All the words in the world to the contrary are not going to change that—ever. That puts the hospital squarely and permanently on top.

This change in status is not being lost on the public, and unless we are very careful to play our cards right, Ralph Naders are going to spring up from under every rock to take our place as patient advocates. Then they, and not we, will be calling the shots. They will be doing it through the courts, and the lawyers will be crying all the way to the bank.

I am far from certain that once we have dealt ourselves that hand, it will be possible to play it right. Then, as Caesar said when he crossed the Rubicon, "*Alea iacta est!*"

So roll 'em. But beware that precipice down the pike.

Impairment Ratings

In March we carried a paper by Drs. Gaw and Emerson, with accompanying editorial comment, that emphasized the importance of accuracy and consistency in rating impairment, and the necessity for using the *AMA Guides to the Evaluation of Permanent Impairment* as a tool (*J Tenn Med Assoc* 89:77-78, 94, March 1996).

The paper prompted a letter from one of our members, James B. Talmage, MD, who reminds us that there is an organization, the American Academy of Disability Evaluating Physicians, of which he is a Fellow, that teaches doctors how to do proper evaluations. He goes on to say that in May the Academy is offering a workshop on the basics of disability evaluation. For particulars, I refer you to Dr. Talmage's letter to the editor, which appears in that section. I encourage those of you who are doing evaluations and who might be unsure of the details you need to be giving attention to in making those evaluations to take advantage of this opportunity. It is your duty to your patients, to your colleagues, and to yourself. □

It's Time To Take Off the Gag

TMA Takes Progressive Action To Head Off Managed Care Gag Rules

Betsy Kauffman Humphrey

It's a rule the general public knows little about and one that most doctors dread: being told by an insurance company or managed health care organization (MCO) that a treatment is too expensive, too experimental or simply not covered by their plan, so the doctor is contractually forbidden to tell the patient about it.

It's happened in other states, and some physicians have found themselves caught in a nightmare that boils down, quite simply, to making a living or doing their duty to patients, often violating a contractual clause that can lead to horrendous legal debts.

Some health care plans even offer physicians financial incentives for limiting their care.

They're called gag rules or gag clauses and under a state regulation proposed by the Tennessee Medical Association, including such a clause in a contract between an insurance company and a physician in Tennessee would be considered practicing medicine without a license.

While no health care provider in the state has written such a rule into its contracts, the TMA wants to ensure they don't by making it illegal and unethical for insurance companies and MCOs to attempt to—or for physicians to agree to.

In February, the TMA submitted to the Tennessee Board of Medical Examiners a regulation prohibiting such gag rules in physician contracts with third-party payers. If adopted, the regulation would make Tennessee the third state—following Massachusetts and New Jersey—to make such clauses illegal.

Jerry Kosten, Tennessee Medical Board spokesman, said the Board "is in favor" of the regulation but has some con-

"If a doctor is treating you, you're his patient and it's up to him to tell you all he can about your treatment options, even if they're not covered by your insurance plan."

—Sen. Douglas Henry (D-Nashville)

cerns about the language used by the TMA. The Board referred the proposal to their attorney, who is "tinkering" with the regulation's wording to put it in the proper form and was expected to have a revised version for the Board to consider at its March meeting.

While the Board generally doesn't have jurisdiction over

insurance companies, it does have authority over Tennessee-licensed physicians. Making such clauses illegal for physicians to agree to would head off any insurance companies' plans to require them.

Ron Harr, vice-president of communications for Blue Cross/Blue Shield of Tennessee, the state's largest health care insurer, said the company has reviewed the proposed regulation and decided not to take a position on it.

"We don't have any gag clauses in our contracts and we don't intend to have any in the future, so this really doesn't affect us," Harr said. "On the other hand, we don't believe a lot of these things need to be legislated or regulated."

If the Board adopts the regulation, it will be either as an emergency rule, which would be passed on for State Attorney General Charles Burson's approval, or as a standard regulation that would require a public comment period before it takes effect, said Kosten.

Further, a bill in the state legislature sponsored by Sen. Douglas Henry (D-Nashville) and Rep. Roy Herron (D-Dresden) would require managed care companies to notify their policyholders of any restrictions limiting medical personnel from informing them of alternative medical care options.

Henry said he also supports TMA's proposed regulation. "If a doctor is treating you, you're his patient and it's up to him to tell you all he can about your treatment options, even if they're not covered by your insurance plan," he said. "If the TMA can protect people by regulation, that's great."

Ms. Humphrey is a writer for Time Magazine and Reuters News Service; and formerly a Knoxville News Sentinel reporter.

"This is the one thing that was uppermost in physicians' minds last year when we were wrestling with the corporate practice of medicine," said Dr. Charles White, chairman of the TMA Legislative Committee and past president of TMA. "It's trying to head off the notion of medical care being distributed by a bureaucracy."

The regulation, White said, helps fill in the gaps left last year when the state General Assembly adopted a bill doing away with regulations preventing companies, such as hospitals, from practicing medicine. While the bill included "strict guidelines" to protect patients, the TMA-proposed regulation would "strengthen them further," White said, and make sure "physicians would not be hampered by those who have a vested interest in the lowest bottom dollar they can get."

While it isn't intended to stop insurance companies reviewing treatments recommended by physicians, the proposed regulation would:

- Forbid physicians from following any prohibitions on limiting advice to patients, including treatments offered by competing health care plans;
- Make it the illegal practice of medicine—and unethical—for any insurer or third-party payer to limit a physician's full disclosure of treatment options to patients, or stymie the options he or she discloses to a patient;
- Make sure the "nonprofessional, nonmedical judgment"

of insurance companies and third-party payers doesn't dictate to or get in the way of the advice physicians should properly give so that patients can reach an informed decision.

If it's adopted, any physician who violates the rule could have his medical license revoked or suspended.

One of the primary reasons for proposing the regulation as an emergency rule is to head off health care providers es-

tablishing gag clauses as a trend in Tennessee. If that happens, physicians might feel they have no choice but to accept such restrictions. And, White warned, there are those physicians who sign contracts "without reading the fine print," or who are caught in a contract drafted between the insurer and their employer.

"The idea is to strike quickly before the gag rules appear and hurt patient care," said Dr. Robert E. Bowers, TMA president. "It is imperative that the state's physicians move to protect patients from the same types of potential abuses arising from managed care plans in other markets."

Calling gag rules an interference with the doctor-patient relationship, the American Medical Association in January publicly called on managed care plans to cancel such clauses in their contracts with physicians.

"If the public understands this issue, they'll understand that physicians are looking out for their best interests," White said. □

TMA wants to discourage the use of 'gag rules' in Tennessee by making it illegal or unethical for insurance companies or MCOs and physicians to sign contracts that contain such clauses.

Building for the Future

Memphis Integrated Delivery Systems Provide a Glimpse of the Future for Tennessee Doctors

Tim Sewell

As the relationships between physicians and hospitals continue to change in response to the demands of managed care, physicians across Tennessee and the nation can expect to face some major decisions in the years ahead.

In Memphis, some physicians already are being called upon to make those decisions as the city's two largest health care providers—Baptist Memorial Health Care System and Methodist Health Systems—continue to move ahead in the development of their very different forms of integrated delivery systems.

"I believe that in the near future, physicians will for the first time be forced to choose between systems," says Dr. Greg Jenkins, a Memphis physician who served as interim board chairman of the Baptist & Physicians Integrated Delivery System (IDS).

"You'll see less of what we call splitting, physicians serving on the staffs and [preferred provider organizations] of two hospitals. Instead, I think you'll see more system loyalty, especially among the specialists. They'll have to choose which team they're going to be on."

Nearly two years in the making, the Baptist & Physicians IDS is a comprehensive effort to coordinate health care delivery among Baptist-affiliated physicians and the various components that make up the Baptist system. The final com-

"I believe that in the near future, physicians will for the first time be forced to choose between systems."

—Dr. Greg Jenkins, Interim Board Chair
Baptist & Physicians IDS

"You have more integration with physician groups than with physicians and hospitals."

—Dr. Gregory A. Culley, Vice-President
Boston-based HealthCare Connection

ponent of the IDS fell into place on Jan. 31 with the close of the initial physician enrollment period. The initial enrollment period opened in early December 1995 when Baptist officials mailed out invitations to approximately 1,000 area physicians. By the close of the workday on Jan. 31, 879 physicians had applied to participate in the IDS. Of those, 695 asked to become shareholders in the system, which means that they would share in the financial risks as well as the governing duties of the organization.

The other 184 physicians applied

for provider status in the IDS, which means that they would have access to Baptist patients, but they would not be required to take a financial risk and they would not play a part in governing the organization.

"The IDS gives physicians the opportunity to be more involved in the decisions about how care is delivered," Jenkins says. "Right now, we're very involved with the other insurance companies. We have to deal with their referral protocols and the way they perceive that we ought to manage care. By being involved in the IDS, we will have input into those things. We have a part in developing the protocols and the referral network."

Formally created in the fall, the Baptist & Physicians IDS is structured as an equity-based corporation. As such, the organization is owned jointly by Baptist Hospital and the physicians who buy shares in the corporation. Physician shareholders paid \$500 per share to invest in the IDS.

The unique structure of the Baptist & Physicians IDS required the approval of the Tennessee Department of Com-

Mr. Sewell is a reporter for the Memphis Business Journal and writes frequently for the Memphis Health Care News.

merce. State officials even set a goal for the number of physicians to be involved in the organization. Under that state-mandated goal, Baptist Hospital was required to sign up at least 450 physician shareholders, of which at least 100 had to be primary care physicians. Of the 695 physicians who did apply to become shareholders, 186 are primary care physicians and 509 are specialists. Of the 184 physicians who sought provider status, 19 are primary care physicians and 165 are specialists.

Integrated delivery systems, designed to help contain health care costs, maintain quality of care, and improve patient access and convenience, are being established at hospitals across the nation. The organizations all have similar goals, but they may take very different forms. While Baptist Hospital, for instance, sets up a formalized in-house structure,

Methodist Hospital is developing its own form of IDS by working with payers outside the system, according to Dr. Ron Lawson, vice-president of medical affairs for Methodist Hospitals of Memphis.

"At Methodist, we've chosen to link with payers such as Cigna and work within their infrastructures with regard to physician profiling and credentialing," Lawson says. "We really have integrated systems with our partners more than we do with ourselves."

"Baptist has chosen the other tactic. My guess is that we'll get to that point eventually," Lawson adds. "As the marketplace evolves, Methodist will become less oriented toward partners and more toward themselves. We'll have more in-house relationships."

Right now, Methodist Hospital has a functioning physician-hospital organization, or PHO. The physician arm of that organization is Metro Care Physicians. The integrated delivery arm is known as Health Choice Managed Care Plan.

"It comes down to how you define integrated delivery system. At this point, we have a functioning, integrated PHO," Lawson says. "We have many aspects of that system already functioning. But we have very little physician financial risk at this point. Most of our methodologies are straight-out caps or a fee-for-service environment."

Dr. Gregory A. Culley, vice-president of the Boston-based consulting group HealthCare Connection, has worked with Methodist Hospital officials since 1991 to help the system develop its own brand of IDS. He says that the varying models of IDS being developed by Baptist and Methodist Hospitals represent the range of delivery system options being de-

veloped in cities around the country.

"There is no one model out there. There is a very wide range of integrated delivery systems," Culley says. "At one extreme, you have the fully integrated delivery systems, and at the other end of the spectrum you have the loosely knit PHO."

In a fully integrated system, all physicians work for the health care system through their own health maintenance organization (HMO). In a loosely knit PHO, all physicians

are involved through a loose association with the hospital. The PHO then enters into contracts with managed care organizations.

"The PHO is the most common type of IDS right now," Culley says. "There is a tremendous amount of movement in this direction. When you look at all the managed care contracts that are out there, the vast majority of those, well over 50%,

are with individual physicians and individual hospitals—not with groups. I would say that for the most part complete integration of independent physicians with hospitals is something that has not yet reached what a lot of people said it would."

As the physician leaders of the efforts to create integrated delivery systems at their respective health care systems, both Jenkins and Lawson say they have had to respond to a number of physician concerns. While physicians, for instance, generally agree on the financial advantages of an IDS, they worry about a loss of freedom and autonomy.

"Physicians as a group are opposed to people telling us what we ought to do," Jenkins says. "Take protocols, for instance. I see protocols as a good thing, but many physicians see them as a negative thing. I see them simply as useful guidelines that we'll be expected to consider when making decisions. Others don't see it that way."

"We're all opposed to what we call 'cookbook medicine,' and some physicians are concerned that these protocols may lead to that," Jenkins adds. "I think we'll have more standardization of care. But I believe that we'll always have to make room for differences of opinion on how conditions should be treated and we'll still have to individualize care. But the guidelines should be helpful for us to see how other doctors are doing it. I also think the doctors will be more apt to go by the guidelines if we have some input in their development."

According to Jenkins and Lawson, there also are concerns that some physicians might be "left out in the cold" in the new IDS environment.

*"We don't want to see managed care
create chaos in this community and we
don't want to create an environment where
some physicians have to leave
this community."*

—James Gibb Johnson, MD, President
Memphis & Shelby County Medical Society

"I believe that physicians who truly are efficient providers of care and who practice high-quality medicine with true quality measures will be financially rewarded for that. They will do better in the new environment," Lawson says. "The primary disadvantage is for those who can't meet those standards. As time goes on, those physicians will be left out more and more."

"I don't think that will happen overnight, but physicians need to prepare for that eventuality," Lawson adds. "The systems will be cost-driven in the foreseeable future, so doctors who can't practice cost-efficient medicine will be the ones to suffer. It comes back to efficiency of practice. It comes down to what we measure—cost and later quality of care."

Lawson says he believes that in the future physicians will be divided into three groups. The first group will include those physicians who are left out in the cold.

"When you're reimbursed for a given population of patients with a primary gatekeeper methodology, you need only a certain number of physicians," Lawson says. "Regardless of how they're selected, only a certain number of physicians will be able to care for that select group of patients. Baptist is further along in that methodology. That relates to their more structured relationships with their doctors."

The second group, according to Lawson, will include an intermediate level somewhere between the capitation and the full fee-for-service. Lawson says this group will include those physicians who are in a point-of-service health maintenance organization (HMO) or preferred provider organization (PPO) plans that are somewhat restricted.

"I think that will be the largest group in our community in the foreseeable future," Lawson says. "You'll see physicians come and go in that group."

The third group will include the full fee-for-service physicians. Lawson says that, as Medicare evolves into an HMO setting, that group will flow into the first group. That group will include Medicare and some of the commercial carriers that aren't aligned with either Baptist or Methodist, he says.

Both Lawson and Jenkins believe that as the integrated delivery systems develop, most Memphis-area physicians will have to become aligned with either Baptist or Methodist Hospitals.

"A lot of physicians aren't comfortable with that. I'll admit that I'm not convinced that choosing systems is necessarily a good thing," Jenkins says. "Some physicians want to continue working in two or more systems. They're skeptical about being loyal to one particular system. That's something we'll have to deal with in the future."

Dr. James Gibb Johnson, executive associate dean in the College of Medicine at the University of Tennessee, Memphis, is the current president of the Memphis & Shelby County Medical Society, an organization that represents approximately 1,400 Shelby County physicians. Johnson says he disagrees

with the prediction that all Shelby County physicians will be divided into two opposing camps in the near future.

"I think that's a pessimistic view," Johnson says. "In the first place, I wouldn't count out the St. Francis Hospital system. In addition, the university's medical group spans a number of hospitals and has relationships with Baptist, Methodist, St. Francis, St. Jude [Children's Research Hospital], UT Bowld [Hospital], St. Joseph [Hospital], and the [Veterans Affairs Medical Center].

"We actually have a number of systems with many different areas of quality," Johnson adds. "Over the next few years, each system will have to do things to become more efficient and control its cost. We expect that to happen. But we don't want to see managed care create chaos in this community and we don't want to create an environment where some physicians have to leave this community."

According to Johnson, the local medical society is taking steps to ensure that all area physicians are equipped to handle the development of the integrated delivery systems and the other changes occurring in response to managed care.

"Helping our members adapt to managed care while still maintaining high quality care is one of our primary goals for the coming year," Johnson says. "Now, we're beefing up our information to the membership about potential pitfalls with various managed care contracts. We especially want to make sure that they understand the long-term effects of such things as non-compete clauses in some contracts. We're also considering the development of a report card process to help our members make well-informed decisions."

According to Culley, there actually has been more integration among medical practices within the past few years than between physicians and hospitals.

"You have more integration with physician groups than with the physicians and hospitals," Culley says. "We are seeing more and more physician integration where primary care physicians are pulling together in virtual groups or putting themselves into real groups. We also have networks of primary care physicians and specialists who are pulling together in order to take managed care risks. Some associate with hospitals and some do not."

Culley says he believes that in the near future more physician networks will be created along with more integrated delivery systems in all their many forms.

"I certainly see more PHOs being formed, and I think there will be true integrated delivery systems. But I think it will still be a mixed bag," Culley says.

"Those integrated delivery systems that develop true partnerships with physicians and those hospitals that really allow physicians to have a say in the governance and in the management of the risk and those that allow physicians to have an equitable share of any profits off managed care contracts will be the ones to survive." □

Preventive Medicine Series

Grading TennCare

Cyril F. Chang, PhD; David M. Mirvis, MD

Two years ago, Tennessee replaced its Medicaid program with a \$3-billion experiment named *TennCare*. The new program was designed to control the unmanageable growth in Medicaid spending, expand access to health care for the otherwise uninsured and uninsurables, and improve both the quality of and access to health care for those without other forms of health insurance. Has *TennCare* accomplished its objectives? How well is it working? What grade should it get? It is these questions that we shall address in this report.

TennCare's first year was chaotic.^{1,2} Most of the start-up problems initially encountered by enrollees and providers were the result of a lack of experience by both the state and managed care organizations (MCOs) and the tight implementation schedule that did not allow enough time to prepare for a smooth transition from Medicaid to *TennCare*. In the second year, fundamental problems persisted and new problems emerged, even though most start-up glitches had subsided.

Grading TennCare

TennCare, according to its original design, had three major goals. Let us see how well these goals have been accomplished in the first two years.

Goal 1: *Increase access to health care within the context of overall market-based budgetary limits.* This goal must be given two separate grades—one for cost control and one for access expansion. Cost control gets a grade of A. The impetus for *TennCare* was a budgetary crisis, not a health crisis, according to most observers of this ambitious reform pro-

TennCare has succeeded in its first two years in broadening insurance coverage and in slowing the growth of the Medicaid budget. But serious questions are clouding the program's future.

gram.¹ Prior to *TennCare*, the state faced a serious crisis with the Medicaid budget. During the five years prior to *TennCare*, the number of enrollees in Medicaid rose at a compounded annual rate of 13.1% and the cost per enrollee increased by 7.4% per year.² With *TennCare*, the state has averted a pending financial disaster. During state fiscal year 1994, *TennCare* expenditures were less than 1% over the prior year's Medicaid expenditures, a growth rate much lower than in prior years and than the 10% increase in Medicaid rates reported nationally.³

While limiting costs, *TennCare* miraculously expanded insurance coverage to more than 400,000 previously uninsured Tennesseans. Enrollment in *TennCare*, as of October 13, 1995, was 1,186,244 citizens, including 825,042 Medicaid eligibles and 361,201 formerly uninsured or uninsurables (Tennessee Health Law Update, November, 1995). Today, almost 95% of the state's population have insurance coverage (based upon an August 1994 survey conducted by University of Tennessee, Knoxville). Few states, if any, can match Tennessee's progress in broadening health insurance coverage in such a short period of time.

However, insurance coverage is not the same as access to health care. Several studies, including one in Tennessee,⁴ have demonstrated that access to care may remain limited despite expanding insurance coverage. Access may remain constrained because of institutional factors, e.g., shortages of physicians who accept patients with certain coverage, or patient-dependent factors such as limited transportation and limited ability to understand the system, among others.

Access to care has been a significant concern with *TennCare*; that is related to many factors, including negative financial incentives for MCOs to provide service in a capitated system and the purported inadequacy of physician (especially subspecialist) participation.^{3,5} That *TennCare* enrollees have adequate access to a wide range of high-quality

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health services as originally envisioned by the state has not been confirmed by reliable data. Therefore, the state's goals of increasing access to health care gets an incomplete grade.

Goal 2: Improve quality of care. This goal gets an incomplete grade, too. TennCare received federal approval and financial support in part for emphasizing health care quality in theory and on paper. TennCare deserves high marks for such an emphasis.

In practice, however, scientific analyses of the quality of care actually delivered are still unavailable. Much of what is available is based on anecdotes of individual cases with poor outcomes. The delay in availability of comprehensive, patient-level data can be attributed to a lack of experience and foresight in commencing quality assurance and monitoring programs from the beginning. The state's Bureau of TennCare is now compiling data for more comprehensive analyses. Until reliable data become available and are analyzed, quality of care issues cannot be accurately evaluated. As concluded by the Health Care Financing Administration, "since the state is not monitoring providers directly, and no validation system is in place, it has little assurance that services are indeed being given as indicated in the aggregated reports it receives from MCOs . . ." but "the state is making slow progress in implementing its QA monitoring plan."³

Goal 3: Encourage preventive care while providing enrollees incentives for appropriate utilization. Goal 3 also gets an incomplete grade for the same reason. To encourage prevention, preventive services under TennCare are provided free of charge, while other services require deductibles and co-payments based on the enrollees' income. However, this demand-side strategy that makes preventive care free does not guarantee that these services will be provided or utilized. A supply-side strategy motivating or requiring MCOs to engage in these practices must also be in place and rigorously enforced. These and other issues related to delivery of preventive services in managed care systems have been reviewed in a previous paper in this series written by Drs. Bailey and Womeodu.⁶ Without direct data, it cannot be assumed that preventive services are, indeed, being delivered.

- *Are quality, access, and utilization appropriate? Are reliable and effective quality improvement and monitoring plans in place to measure these critical parameters of health system function?*
- *Are incentives to encourage the use of appropriate and preventive care working?*
- *Are the disabled, beneficiaries of the AFDC program, and those who remain uninsured receiving appropriate treatment?*
- *Have formal MCO oversight policies and procedures been developed and strengthened?*
- *Will providers continue to participate in TennCare?*
- *Will MCOs remain financially viable? Is MCO enrollment turnover excessive? What are the reasons for turnover?*
- *Has TennCare caused hospitals to close or to significantly curtail services? If so, what are the consequences to the health care of both the insured and the uninsured?*
- *Has (or to what extent has) TennCare increased cost-shifting to other payers?*

Another major goal of TennCare—appropriateness of health care utilization—is inherently difficult to determine even under the best of circumstances. In the hurry to implement TennCare, these evaluation and data collection issues were also overlooked. Without the necessary data, we cannot determine whether TennCare utilization is appropriate relative to the Medicaid program that it replaced.

Discussion

In sum, TennCare has succeeded in its first two years in broadening insurance coverage and in slowing the growth of the Medicaid budget. But serious questions are clouding the program's future. The access, quality, and

preventive care issues are largely unresolved. Budget constraints have forced the state to close enrollment to the remaining uninsured, raising concern about future access to health care by all Tennesseans. Indeed, the financial pressures that safety-net hospitals such as the MED in Memphis continue to face suggest that access for those not covered by TennCare will, in reality and in contrast to the intent of the program, actually suffer. In a survey by the University of Tennessee, the percentage of uninsured who indicated receiving poor care increased from 13% in 1993 to 25% in 1994, i.e., an increase of over 90% from before to after initiation of TennCare.⁵

Moreover, the payment rates that MCOs pay to hospitals and doctors are below the pre-Medicaid levels. Most MCOs lost money in the first year even after receiving a one-time supplemental payment from the state. According to the General Accounting Office,³ financial reports from MCOs indicated that during the first year of TennCare the five MCOs that covered 60% of all enrollees lost money. Blue Cross/Blue Shield, the largest MCO, reported a loss of \$8.8 million. Losses would have been even greater without large supplemental, disproportionate share payments (\$128 million in 1994) that may not be made in subsequent years. Although all MCOs continue to participate, some have suggested the intent to reevaluate their long-term commitments and others have explored mergers or sales. MCOs are also likely to respond to these losses by further reducing payments to providers or restricting access.

For all of these reasons, TennCare is rapidly approaching

a critical crossroads that could determine the program's long-term success or failure. Gov. Don Sundquist, who inherited TennCare from former Gov. Ned McWherter, must either take a hard line on TennCare costs or find a way to increase TennCare funding if all of its objectives are to be achieved.

The former approach will force the MCOs to squeeze providers harder. Some hospitals and physicians will drop out of TennCare and those that remain will increase cost shifting, a condition that other payers are not likely to permit for long. Some MCOs may not be able to survive the financial crunch, mismanagement, or a concentration of high-cost patients. If an MCO fails, both patients and providers will suffer, for the state does not appear to have a contingency plan to deal with the aftermath of an MCO failure. The second approach, while welcomed by providers, will reverse the major impetus for the program and will crowd out many other worthy programs from the state's overall budget. This means that other constituencies—education, highways, prisons, conservation, social services, etc.—will receive a smaller slice of the state budget.

Apart from financial issues, many health systems and quality issues remain unresolved. Questions that remain unanswered include:

- Are quality, access, and utilization appropriate? Are reliable and effective quality improvement and monitoring plans in place to measure these critical parameters of health system function?
- Are incentives to encourage the use of appropriate and preventive care working?
- Are the disabled, beneficiaries of the AFDC program, and those who remain uninsured receiving appropriate treatment?
- Have formal MCO oversight policies and procedures been developed and strengthened?
- Will providers continue to participate in TennCare?
- Will MCOs remain financially viable? Is MCO enrollment turnover excessive? What are the reasons for turnover?
- Has TennCare caused hospitals to close or to significantly curtail services? If so, what are the consequences to the health care of both the insured and the uninsured?
- Has (or to what extent has) TennCare increased cost-shifting to other payers?

Even though these important questions remain largely unanswered, some lessons can be learned from the first two years of TennCare experience. These lessons include the following:

1. It is possible to expand insurance coverage without a dramatic increase in cost to the government. However, coverage is not the same as access. Coverage will improve access only if reform generates genuine savings so that more people can be covered without sacrificing quality and if nonfinancial barriers to care are reduced.

2. The results of a health system reform plan will not be known for many years. To permit a successful evaluation, data and monitoring issues must be incorporated into the original framework.

3. Major reforms have spillover effects on the entire health care system, affecting the livelihood of thousands of individuals who directly or indirectly work in it.

TennCare's biggest accomplishment has been to bring 95% of Tennessee's residents under some form of health insurance coverage. The main challenge ahead is to continue to control costs while maintaining quality and access for those who cannot otherwise afford health care. This effort will be made more difficult when the federal government shifts new responsibilities to the states.

In an effort to balance the federal budget, the Congress will use block grants to transfer many federal social service functions to the states. The states will have more flexibility to spend the block grants but also will have more programs competing for the limited dollars. Tennessee has been blessed with a reasonably robust economy in the last few years. But business cycles are inevitable. When the next recession comes, possibly in the late 1990s, the commitments we make today will come back to haunt us. □

References

1. Chang CF: TennCare: Tennessee's answer for health care reform. *J Med Prac Manage*, June/July 1994, pp 259-262.
2. Mirvis DM, Chang CF, Hall CJ, et al: TennCare: Tennessee's answer for health care reform. *JAMA* 74:1177-1250, 1995.
3. Medicaid: Tennessee's Program Broadens Coverage But Faces Uncertain Future. US General Accounting Office, Washington, DC, 1995, GAO/HEHS-95-186.
4. Piper JM, Ray WA, Griffin MR: Effects of Medicaid eligibility on prenatal care and pregnancy outcome in Tennessee. *JAMA* 264:2219-2223, 1990.
5. Mathematica Policy Research. Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee, 1995; a report prepared for the Henry J. Kaiser Family Foundation and the Commonwealth Fund, Washington, DC.
6. Bailey JE, Womeodu R: Prevention in managed care: obstacles and opportunities. *J Tenn Med Assoc* 89:122-125, 1996.

Loss Prevention Case of the Month

Complication During Arthroscopy

J. Kelley Avery, MD



Dr. Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

A 56-year-old truck driver with a long history of pain in his knees had previously had arthroscopic surgery on his right knee for osteochondritis with fair results. Now the left knee was so painful that it interfered with his work. The pain was aggravated by long periods of walking and lifting. Driving his truck caused aching in his knee to the degree that he would have to stop his truck, get out, and walk around to get some relief, only to have the same problem recur when he resumed driving. These symptoms were the same that he had experienced with his right knee, and the surgery four years earlier had helped a lot. His physician recommended the same approach to his left knee, with the caveat that it would probably delay the inevitable arthroplasty for a few years.

For years the obese patient had experienced moderately severe hypertension that was difficult to control. His treatment had been Atenolol, Vasotec, and Catapres. He was admitted to the outpatient surgery area, where the note by the anesthesiologist indicated that he had been informed of the risks and benefits of the knee operation by the orthopedic surgeon and agreed to the arthroscopic surgery for debridement of the joint. Preoperative medication was given about 12:45 PM. At 1:00 PM an epidural anesthetic was administered. The procedure went smoothly and without incident, using xylocaine and epineph-

rine, with good analgesia. The surgery began about 2:00 PM and ended about an hour later. He was transferred to the post-anesthesia care unit (PACE) in good condition, but still unable to move his lower extremities.

It is significant to note that the operating room clinical record did not mention a blood pressure reading during the procedure. However, after transfer to the PACE, about one and one-half hours after the epidural had been given, the blood pressure was reported to be 148/90 mm Hg.

The anesthesia record indicated that the blood pressure was tracked at 80-90 mm Hg systolic during the one-hour operation. Intravenous fluids were running, the patient receiving about 2,000 cc preoperatively and intraoperatively.

The patient remained unable to move his lower extremities while in the PACE. Three hours after the anesthesia had been given the patient was transferred to a bed on the floor, still unable to move his legs. Thirty minutes later the surgeon was called about the patient's condition. He asked that a resident see and evaluate the patient. The patient then was transferred to a 23-hour observation bed. At 10:15 PM the blood pressure was recorded at 160/100 mm Hg, and throughout the night and early morning hours it remained at about this level or higher, on one occasion reaching 206/110 mm Hg.

At 8:00 AM the morning after the surgery the patient was seen for the first time by his anesthesiologist and his surgeon. At this time a consultation was asked of a neurologist, who found the patient still unable to move his legs, but with some ability to flex at his hips. The circulation seemed intact in his legs, and he had some perception of touch but no pain on pinprick. CT and MRI were both negative. EMG showed no motor function in the lower extremities, indicating a lesion at the L2-3 level. The diagnosis was occlusion of the anterior spinal artery, presumably brought about by the prolonged hypotension (one hour) during surgery. The patient did not recover significant function, and remains paraplegic.

A lawsuit was filed charging the surgeon and the anesthesiologist with negligence in not treating the intraoperative hypotension, which was presumed to be the causative factor in the diagnosis. The complaint further charged that there was no informed consent for the anesthesia.

Loss Prevention Comments

Again the record condemns us! There is no record of an informed consent that discussed the epidural anesthetic itself. The rather prolonged period of hypotension during the operation was not treated. It is certainly open to question whether or not one hour of systolic pressure readings of 80-90 mm Hg would contribute to the occlusion of the anterior spinal artery, but this patient had been hypertensive for years and was taking treatment for his hypertension preoperatively. Then there was the prolonged interval between the time the surgeon became aware that the patient could not move his legs and his personal appearance at the patient's bedside. Neither the surgeon nor the anesthesiologist came

to see the patient until the next morning, some 18 hours after the anesthetic had been given. While this could not have contributed to the result, it probably did contribute to the anger felt by the patient toward the operating team.

Expert witnesses stated unequivocally that the period of hypotension could have contributed to the final outcome, and indicated that prompt intervention by the anesthesiologist could have prevented or mitigated the resulting paralysis.


Considering that our doctors had no expert witness support, and that the patient had been a productive working man prior to his operation, trying this case was out of the question and a very large settlement was required to close this case. □

HELP FOR IMPAIRED PHYSICIANS

The Tennessee Medical Foundation Impaired Physician Peer Review Committee assists doctors who are suffering from the disease of chemical dependence, or mental or emotional illness, or both, including certain behaviors problematic for physicians. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease or illness is detected early. The Committee urges family, friends, and associates to avoid misguided sympathy which enables a physician's impaired condition to deteriorate.

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Original Contribution

Diagnosis of Meckel's Diverticulum By Computerized Tomography

Robert W. Ikard, MD

Introduction

Meckel's diverticulum is found in 1% to 2% of patients in autopsy series.¹ It causes a similar incidence of clinical difficulty among patients having it, and the diagnosis seldom is made preoperatively.²⁻⁴ Technetium pertechnetate scan is helpful in the few, mostly pediatric, patients with ectopic mucosa lining the diverticulum. Small bowel series (SBS) rarely provides the diagnosis.

Computerized tomography (CT) can detect enteroliths in a giant diverticulum⁵ or a mass if intussusception or infarction have occurred.^{6,7} CT with intestinal contrast provided the correct diagnosis of Meckel's diverticulum in a patient who had had two nondiagnostic SBS and other tests.

Case Report

A 30-year-old man had intermittent, cramping abdominal pain, occasionally associated with nausea and lasting from hours to days. He had lost 10 pounds in the past year. As a teenager, he had been treated for iron deficiency anemia. Numerous investigations at that time, including SBS, had provided no diagnosis.

The thin man had a flat, nontender abdomen, without a palpable mass. His hemoglobin was 11.7 gm/dl with normal red blood cell indices. SBS and abdominal ultrasound showed no abnormality. CT with oral and intravenous contrast showed a 2-cm, fluid-filled structure attached to small bowel loops in the right lower quadrant (Figs. 1 and 2).

Celiotomy revealed a diverticulum 45 cm proximal to the ileocecal valve entrapped in adhesions and associated with thickened efferent bowel. The diverticulum and a sleeve of ileum were resected. Sections of the diverticulum showed fibrosis and muscle hypertrophy. Subsequently he has been asymptomatic.

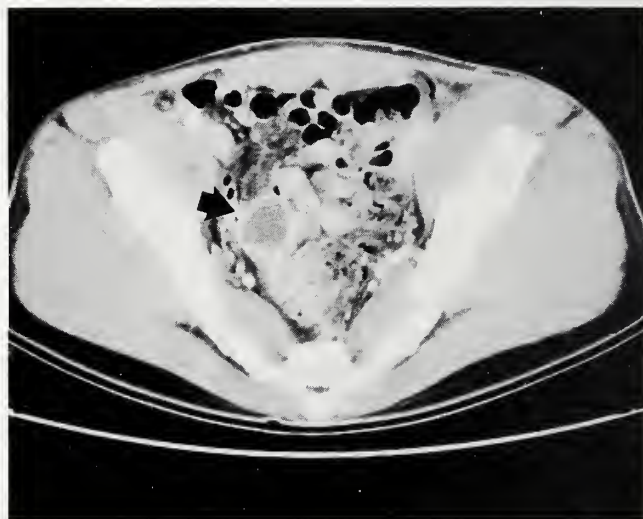


Figure 1. Axial CT image of mid-pelvis, showing ovoid fluid-filled mass.

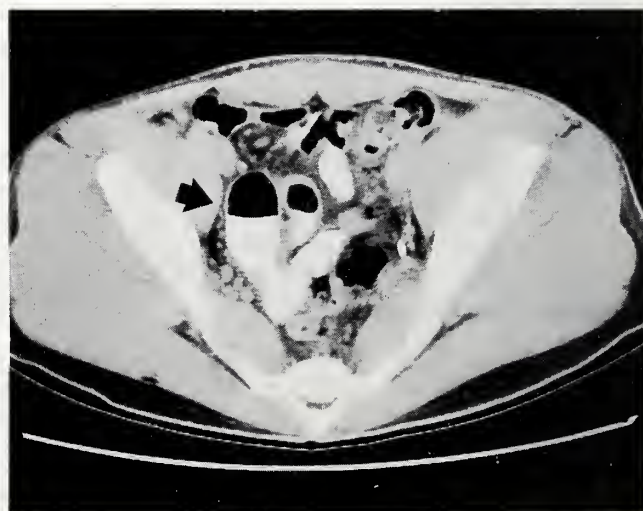


Figure 2. Delayed CT image of mid-pelvis, showing oral contrast medium and air in mass attached to small intestine.

From the Department of Surgery, Centennial Medical Center, and Vanderbilt University Medical Center, Nashville.

Reprint requests to 2400 Patterson Street, Suite 516, Nashville, TN 37203 (Dr. Ikard).

Discussion

Meckel's diverticulum infrequently requires surgical therapy. Though it is removed more often in the pediatric age group, bleeding, obstruction, perforation, or inflammation can occur in later years.^{2,3}

Technetium scanning is seldom helpful in diagnosing clinically significant Meckel's diverticulum in adults. Thoeni and Moss⁷ assert that CT rarely is necessary in diagnosing small bowel disease because conventional procedures are effective and cheaper. In spite of various technique refinements,⁸ however, SBS is unreliable in diagnosing Meckel's diverticulum.

Because of the anomaly's rare clinical import, it is unlikely that prospective analysis of relative efficacy of SBS and CT for diagnosing Meckel's diverticulum can be done. Other recent reports of correct preoperative diagnoses using CT suggest the modality may be more accurate than SBS.^{9,10} In this case, CT interpretation identified the diverticulum after SBS and ultrasound had failed. Judging from these re-

ports, CT should be used earlier in the clinical algorithm, probably providing a higher diagnostic rate with less, rather than more, expense. □

References

1. Sloan RD, Stafford ES, Singewald ML, et al: Meckel's diverticulum. *Am J Roentgenol* 71:54-75, 1954.
2. Yamaguchi M, Takeuchi S, Awazu S: Meckel's diverticulum: investigation of 600 patients in Japanese literature. *Am J Surg* 136:247-249, 1978.
3. Mackey WC, Dineen P: A fifty year experience with Meckel's diverticulum. *Surg Gynecol Obstet* 156:56-64, 1983.
4. DiGiacomo JC, Cottone FJ: Surgical treatment of Meckel's diverticulum. *South Med J* 86:671-675, 1993.
5. Torii Y, Hisatsune I, Imamura K, et al: Giant Meckel diverticulum containing enteroliths diagnosed by computed tomography and sonography. *Gastrointest Radiol* 14:167-169, 1989.
6. Russ PD, Friefeld GD, Nauck CJ, et al: Infarcted Meckel diverticulum detected by CT. *Am J Roentgenol* 150:299-300, 1988.
7. Thoeni RF, Moss AA: The gastrointestinal tract, in Moss AA (ed): *Computed Tomography of the Body*, ed 2, vol 3. Philadelphia, W.B. Saunders Co, 1992, p 679.
8. Perne AS: Meckel's diverticulum. *N Engl J Med* 260:690-696, 1959.
9. Black ML, Ros PR, Smirniotopoulos JG, et al: Intussuscepted Meckel diverticulum: radiologic-pathologic correlation. *Comput Radiol* 11:244-248, 1987.
10. Nigogosyan M, Dolinskas C: CT demonstration of inflamed Meckel diverticulum. *J Comput Assist Tomogr* 14:140-142, 1990.

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Vanderbilt Morning Report

Antiphospholipid and Anticentromere Antibodies Occurring Together in a Patient With Pulmonary Hypertension

Case Report

A 34-year-old man came to Vanderbilt University Medical Center for evaluation of presumed thromboembolism and pulmonary hypertension. Fifteen years earlier the patient developed a deep venous thrombosis and pulmonary embolus. Despite warfarin therapy he had recurrent venous thromboses and an axillary artery thrombosis. Pulmonary hypertension developed and five months before admission a Greenfield filter was placed in the vena cava. The patient complained of progressive dyspnea on exertion and was admitted to a community hospital for evaluation. Warfarin was discontinued and heparin was given intravenously. A pulmonary arteriogram was attempted but aborted because of high pulmonary artery pressure, and he was transferred to our hospital for further evaluation.

Physical examination showed a well-developed white man in no distress, with a body temperature of 99.7°F, blood pressure 120/68 mm Hg, and pulse 82/min. His respiratory rate was 22/min while he was receiving 3 liters of oxygen per minute by nasal cannula. There was no apparent jugular vein distension at 30 degrees elevation. The lungs were clear to auscultation and percussion. Cardiac examination showed a loud P₂ and an accentuated splitting of the second heart sound with inspiration. There was no gallop or right ventricular heave, and there was no clubbing, cyanosis, or edema of the extremities. There was no rash or synovitis, and the skin texture was normal. The WBC count, hematocrit, and electrolytes were all normal. The platelet count was 57,000/cu mm, and the PTT was 59 seconds (normal 26). The electrocardiogram revealed a sinus tachycardia at 110/min, right axis deviation, and right ventricular hypertrophy. The chest radiograph showed cardiomegaly, with a prominent right heart border and prominent pulmonary arteries. A ventilation-perfusion scan was read as low probability for pulmonary embolus. An echocardiogram showed severe right ventricular enlargement, markedly decreased right ventricular func-

tion, and right atrial enlargement. Infusion of agitated saline failed to reveal an intracardiac shunt. Cardiac magnetic resonance imaging (MRI) showed no thrombus in the main or the right or left pulmonary arteries. A pulmonary arteriogram showed chronic minimal occlusive disease in the postero-basal segments only. The apical and mid-arterial branches were unremarkable. Pulmonary artery pressure was 81/34 mm Hg. There was no oxygen differential between the right atrium and pulmonary artery.

The PTT remained elevated several days after the discontinuation of heparin, but thrombin time was normal. A 1:1 pooled normal plasma mix failed to correct the PTT. A lupus anticoagulant screen revealed an elevated dilute Russell's viper venom time, and dilute thromboplastin time. Anticardiolipin antibody was positive, with an IgG titer of 113 (normal 0 to 23). Antinuclear antibody was positive at a titer of 1:160 in a 4+ centromere pattern. Anti-DNA crithidia and ENA were negative. Rheumatoid factor was less than 1:20. There was no history or physical findings to suggest systemic lupus erythematosus or systemic sclerosis. The patient was discharged receiving warfarin, nifedipine, and oxygen. He has remained stable during more than two years of follow-up. The PT INR is kept at 3.0 to 4.0. No other manifestations of immune vascular disease have occurred. The main complications of his disease have been exercise intolerance (New York Heart Association Class III), mild hypoxemia, and two episodes of frank hemoptysis.

Discussion

Our patient displayed several features of the primary antiphospholipid syndrome, including recurrent vascular thrombosis, thrombocytopenia, and antibodies to a phospholipid.¹ Pulmonary hypertension is a rare manifestation of the antiphospholipid syndrome, occurring in only two of 70 patients in one series.² Pulmonary hypertension in the primary antiphospholipid syndrome has been shown to occur by both thromboembolic and primary vasculopathic processes.³ Both mechanisms were potentially responsible in our patient since the degree of pulmonary hypertension was out of proportion to

Presented by Steve Tilley, MD, Department of Pulmonary Fellowship at Chapel Hill, North Carolina; Discussed by John Newman, MD, professor of pulmonary medicine, and Anne Thomas, MD, assistant professor of medicine and hematology, Vanderbilt University Medical Center, Nashville.

(Continued on page 168)

Trauma Rounds

An Abdominal Hernia Secondary to Blunt Trauma

James V. Lewis, MD; Roger C. Clapp Jr., MD; George M. Testerman, MD

Introduction

An acute abdominal wall hernia following blunt trauma occurs infrequently. In 1994 Damchen et al¹ collected 23 clearly described cases from the world literature and reported five additional cases from their institution. They defined blunt abdominal herniation as "herniation through disrupted musculature and fascia associated with adequate trauma, without skin penetration, and no evidence of a prior hernia defect at the site of injury." The absence of peritoneal sac has been included in the criteria for diagnosis.² This is the report of the presentation and management of such a hernia.

Case Report

A 43-year-old woman was involved in a single car motor vehicle crash. She was the unrestrained front seat passenger in a car that collided with a front porch, the side railing of which penetrated the windshield and struck the patient in the abdomen. There was no loss of consciousness or hemodynamic instability. Upon arrival in the emergency department the patient was alert and complaining only of right-sided abdominal pain.

On physical examination a large, minimally tender, ecchymotic area and bulge were noted in the right lower quadrant of the abdomen. The overlying skin was intact. Bowel sounds were normal.

A CT scan of the abdomen (Fig. 1) revealed protrusion of the colon through a large defect in the right lower anterolateral abdominal wall. The bowel extended to within a few millimeters of the skin and appeared intact, without evidence of free air. There was no other evidence of intra-abdominal injury.

With increasing abdominal pain the patient was taken to surgery for exploration and repair of the hernial defect. The trauma had disrupted the fascial layers of the abdomen as well as the right rectus and oblique muscles. No hernia sac was present, and the colon appeared uninjured. The distal ileum and cecum were avulsed from their mesenteries, as

was a small portion of distal jejunum. An ileocolicectomy and distal jejunal resection were performed with primary anastomoses. The hernia defect was closed in layers with non-absorbable sutures. The patient had an uneventful recovery and was discharged on the seventh postoperative day. Two months after her injury the patient's abdominal wound was well healed without evidence of recurrence.

Discussion

Blunt abdominal trauma is common, as are injuries to the abdominal wall, in the form of contusions, hematomas, and abrasions. The greatest emphasis, understandably, is on the diagnosis and management of underlying visceral injuries. Diaphragmatic hernias do occur, but are thought to be secondary to sudden increases in intra-abdominal pressure rather than to direct trauma.³

The mechanism of injury that might explain the sudden development of an abdominal hernia is the application of a large amount of force, sufficiently blunt as not to penetrate the skin, and concentrated enough to produce focal muscular damage. This is easily pictured when the source of trauma is a handlebar, but the end of a porch rail would certainly be an

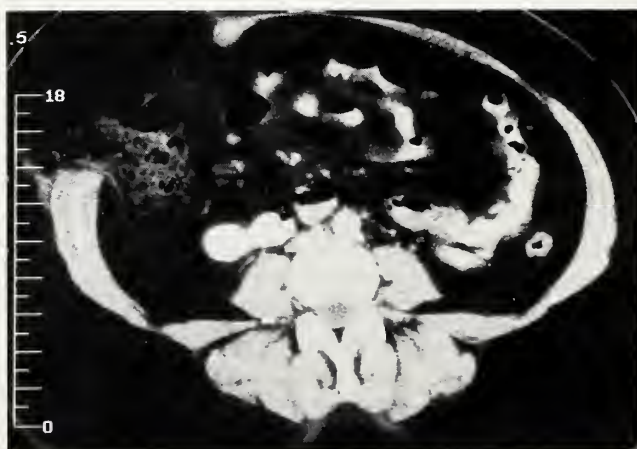


Figure 1. Admission CT scan of the abdomen showing disruption of the musculature and herniation of bowel into the defect.

From the Department of Surgery, James H. Quillen College of Medicine, East Tennessee State University, Johnson City.

adequate instrument.

Since these hernias form abdominal wall masses, the differential diagnosis would include, in addition to an acute hernia, a rectus muscle hematoma and a preexistent tumor.⁴ When the diagnosis is uncertain, plain abdominal x-rays may show bowel gas in the hernia. GI contrast studies have been reported as useful, as have ultrasonography and CT scans.⁵

The patient described here had an acutely symptomatic hernia, and because of its size the diagnosis was evident. The CT scan, however, gave a good picture of the disruption that had occurred.

Immediate exploration and repair are recommended as the appropriate course of management in these cases.^{2,6} In the cases collected by Damschen et al,¹ 11 of 28 patients had associated intra-abdominal injuries. With this in mind, the need for abdominal exploration would make a midline incision preferable over one that overlies the hernia itself. The hernial defect may be easiest to repair when fresh. Adequate debridement and a solid, tension-free repair with non-absorb-

able sutures and occasionally with synthetic mesh is also recommended.⁴

Morbidity from a traumatic hernia of the abdominal wall is directly related to associated injuries, both within the abdomen and to other areas of the body. In Damschen's review of all reported cases, no deaths are mentioned.¹

In summary, an acute abdominal wall hernia secondary to blunt trauma occurs infrequently. When recognized, immediate repair coupled with adequate abdominal exploration is the management of choice. □

References

1. Damschen DD, Landercasper J, Cogbill TH, et al: Acute traumatic abdominal hernia. *J Trauma* 36:273-276, 1994.
2. Malangoni MA, Condon RE: Traumatic abdominal wall hernia. *J Trauma* 23:356-357, 1983.
3. Dubois PM, Freeman JB: Traumatic abdominal wall hernia. *J Trauma* 21:72-74, 1981.
4. Wood RJ, Ney AL, Bubrick MP: Traumatic abdominal hernia: a case report and review of the literature. *Am Surg* 54:648-651, 1988.
5. AL-Qasabi QO, Tandon RC: Traumatic hernia of the abdominal wall. *J Trauma* 28:875-876, 1988.
6. Guly HR, Stewart IP: Traumatic hernia. *J Trauma* 23:250-252, 1983.

Vanderbilt Morning Report . . .

(Continued from page 166)

the small amount of thrombotic disease found by arteriogram.

The presence of an anticentromere antibody was an unexpected finding. Of 99 patients with the primary antiphospholipid syndrome in three series, none have been reported to have anticentromere antibodies.^{2,4,5} Anticentromere antibodies are frequently associated with the CREST syndrome, and were once considered a serologic marker for this variant of scleroderma. More recent studies have shown anticentromere antibodies to be less specific. Out of 4,800 randomly screened patients, 24 (0.5%) were found to have anticentromere antibodies.⁶ Eight of these 24 patients had no connective tissue disease. The others had either primary biliary cirrhosis, primary Raynaud's phenomenon, CREST, diffuse scleroderma, or pulmonary hypertension. It is unknown whether the patient with pulmonary hypertension was tested for antiphospholipid antibodies. Twenty percent to thirty-three percent of patients with systemic sclerosis have anticardiolipin antibodies, one of the most common antiphospholipid antibodies. However, no patient with anticardiolipin antibody has ever been reported to have anticentromere antibodies.⁷

The potential role for antiphospholipid antibodies in the pathogenesis of pulmonary hypertension has recently been reported.³ The role of anticentromere antibodies in pulmo-

nary hypertension is uncertain, but an association is likely given the frequency of pulmonary hypertension in patients with the CREST syndrome.⁸ Furthermore, one of the 24 randomly screened patients found to have anticentromere antibodies had pulmonary hypertension as the sole clinical manifestation.⁶ Our patient showed the unique combination of antiphospholipid and anticentromere antibodies, both of which may be mechanistically involved in the pathogenesis of his pulmonary hypertension. □

References

1. Asherson RA: A primary antiphospholipid syndrome. *J Rheumatol* 15:1742-1746, 1988.
2. Asherson RA, Khamashta MA, Ordi-Ros J, et al: The primary antiphospholipid syndrome: major clinical and serological features. *Medicine* 68:366-374, 1989.
3. Luchi ME, Asherson RA, Lahita RG: Primary idiopathic pulmonary hypertension complicated by pulmonary arterial thrombosis associated with antiphospholipid antibodies. *Arthritis Rheum* 35:700-705, 1992.
4. Alarcon-Segovia D, Sanchez-Gerrero J: Primary antiphospholipid syndrome. *J Rheumatol* 16:482-488, 1989.
5. Mackworth-Young CG, Loizou S, Walport MJ: Primary antiphospholipid syndrome: features of patients with raised anticardiolipin antibodies and no other disorder. *Ann Rheum Dis* 48:362-367, 1989.
6. Lee SL, Tsay FJ, Tsai RT: Anticentromere antibodies in subjects with no apparent connective tissue disease. *Ann Rheum Dis* 52:586-589, 1993.
7. Katayama I, Otoyama K, Kondo S, et al: Clinical manifestations in anticardiolipin antibody-positive patients with progressive systemic sclerosis. *J Am Acad Dermatol* 23:198-201, 1990.
8. Salerni R, Rodnan GP, Leon DF, et al: Pulmonary hypertension in the CREST syndrome variant of progressive systemic sclerosis. *Ann Intern Med* 86:394-399, 1977.

Department of Health Report

Project TEACH in the School System

Judith M. Womack, RN

Project TEACH (Together Educating and Coordinating Health) began in January 1995 as a cooperative effort between the Tennessee Department of Health and the Tennessee Department of Education. The Project was intended to increase coordination of services to children with special health care needs, and to improve the capability of local school systems to access third party payors for services derived. The project began as a result of a dramatic increase in the number of students with special health care needs attending public school in Tennessee. Contributing factors to this increase include the advance of medical technology at a faster rate than schools' capacity to deal with the special needs of students, the increased legal requirements to serve all students with disabilities, the trend toward outpatient treatment rather than treatment in an acute care facility, and parents' expectations regarding their child's right to medical care in the school. Because many of the students with special needs are mainstreamed, not all are classified as special education students, thus increasing problems associated with the care of these children in the regular classroom:

- School systems do not have staff trained to perform medical procedures in the classroom, nor do they have the resources to employ such individuals.
- Teachers are provided who have no training in dealing with medical problems, or information for helping them understand the child's medical need.
- Children often need more services than can be provided during the school day or the school year, and few children are approved for extended school-year services.
- Therapy delivered during the school day is not coordinated with that delivered privately after school.
- Larger school systems may have some personnel on site to deliver therapy services, but the smaller ones have to contract for those services at significant expense.
- School systems do not have the medical expertise or the personnel to access third party payors.

By coordinating school-based case management activities for this population with other resources, school systems

benefit from both enhanced medical expertise and more extensive provider networks. School-based case management is not the direct provision of services, but rather the enhancement of medical care by providing integration of nonmedical services and educational activities with continuing medical care.

Representatives from both state departments met with special education supervisors in each region, and outlined for them the proposed activities. Pilot projects were defined and staffed with experienced public health nurses who were initially involved in data collection as their primary activity. Health survey forms were sent to the family of each child enrolled in the designated school systems. The return rate of the completed health surveys has been 93%. Review of the surveys indicated that approximately 5% of the children in the involved school system in the East Tennessee and 15% of the children in the West Tennessee school system had some type of health-related problem. Because the focus has been to improve financial access to services, many of the services previously paid for out of local school system funds are now being funded through other third party mechanisms.

The Project TEACH nurses are now regularly attending multidisciplinary team meetings. As a result, other benefits have been noted.

- Children receiving therapy have been discussed and in many instances channeled into services that more appropriately meet their needs.
- Many children with health problems that the schools knew nothing about previously that could have significant impact in the classroom have been identified.
- Resources that have been unknown to the school staff have been identified, and duplication of effort has been avoided by increased access to records from other providers.
- Diagnosis-specific information has been researched and has been provided in written form to school personnel.
- Project TEACH nurses have planned and implemented summer services supported by third party payors for students with special health care needs.

Project TEACH is currently being expanded into six other areas of the state. Specific information about the program may be obtained by calling the Case Management Services Section of the Department of Health at (615) 741-8530. □

From the Tennessee Department of Health, Nashville, Ms. Womack is director of Case Management Services for the TDH.

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Letters to the Editor

Disability Evaluations

To the Editor:

I agree both with the article by Drs. Gaw and Emerson and with the editorial in the March issue of the *Journal* on the subject of AMA Guides and Impairment Ratings (*J Tenn Med Assoc* 89:77-78, 94, March 1996).

There is an organization that teaches how physicians should do impairment ratings. The American Academy of Disability Evaluating Physicians will be having one of their overview courses at the Stouffer Hotel in Nashville on Saturday and Sunday, May 18 and 19. The course is meant for the practicing physician as well as the disability specialist.

For information contact the American Academy of Disability Evaluating Physicians, 150 N. Wacker Dr., Suite 920, Chicago, IL 60606; Phone (312) 658-1171, Fax (312) 658-1175.

James B. Talmadge, MD
500 Old Kentucky Road, Suite 522
Cookeville, TN 38501

TMA Alliance Report

A Year of Firsts

The Tennessee Medical Association Alliance will conclude a very busy year at the Sixty-Eighth Annual Convention in Knoxville, headquartered at the Hyatt Regency Hotel on April 11-13. On Saturday, April 13, Annette Bond of Nashville will be installed as president by Sharon Scott of Roseburg, Oregon, the American Medical Association Alliance (AMAA) president.

The theme for the 1995-1996 year was "WE . . ." Using a tree as a symbol, WE made up the roots of the Alliance. The trunk of the tree was made up of action verbs that indicated the many ways the Alliance works to enhance the image of medicine in our communities, i.e., plan, advocate, share, include, raise funds, and provide care. The leaves and fruit of the tree are the results of our actions, i.e., Teen Health Workshops, working with the TMA on the Domestic Violence Education and Prevention Photo Exhibit, raising funds for AMA-ERF. During this year, the Alliance emphasized that individuals make up the WE of the Alliance, and our accomplishments are shared by the total membership.

Johnnie Amonette has been nominated for president-elect for the AMAA and will be installed as its president in June, 1997 at its Annual Session. This is quite a feather in Tennessee's cap and Johnnie will be an excellent representative for Tennessee. We are very proud of her and excited about her accomplishment!

It has been a year of *firsts* for the Alliance. We have sat on the TMA Board for the *first* full year, and Dr. Bowers has joined the TMAA Board as the TMA president. Gov. Don Sundquist proclaimed October 11, 1995 as SAVE Day in Tennessee. SAVE stands for the new national Alliance emphasis entitled Stop America's Violence Everywhere. This emphasis was initiated by

Sharon Scott, the AMAA president. Another *first* is that we are now on the shared information network that the TMA has installed at headquarters. We are delighted that we will be able to interface with the Tennessee medical community across the state. Our *first* Jump Start '95 was held last spring. This leadership workshop was conducted in three locations across the state in order to give each county medical association timely training sessions. Our national field director, Barbara Marshall of Dayton, Ohio, participated in our educational and fun meetings. We have established a new county Alliance; we welcome the Overton County Medical Society Alliance, Helen Weissinger, president.

The Alliance appreciates the enthusiastic support of the TMA! The TMAA continues to be committed to the health of all Americans and to the support of our physician spouses. We will continue, through our projects and activities, to be good advocates of medicine. It's been an honor and a privilege to serve as the 1995-96 president of the TMA Alliance.

Lyn Overholt
TMAA Alliance President

In Memoriam

Harry J. Guffee, age 83. Died March 16, 1996. Graduate of Vanderbilt University School of Medicine. Member of Williamson County Medical Society.

Robert L. Patterson, age 84. Died February 27, 1996. Graduate of University of Pennsylvania School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

Leslie B. Reynolds Jr., age 72. Died March 9, 1996. Graduate of Northwestern University Medical School. Member of Sullivan County Medical Society.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

Deborah D. Barton, MD, Soddy Daisy
Thomas A. Cable, MD, Chattanooga
Melinda Darling, MD, Ft. Oglethorpe, GA
Kerry D. Friesen, MD, Chattanooga
Fred M. Gregg III, MD, Chattanooga
Charles Dennis Harris, MD, Chattanooga
David Keith Helton, MD, Chattanooga
R. Hunter Jennings III, MD, Ft. Oglethorpe, GA
Denis T. Kennedy, MD, Chattanooga
Gerhard K. Kraske, MD, Chattanooga
Paul A. Lawrence, MD, Chattanooga
Christopher T. Moore, MD, Lookout Mountain
James J. O'Connell III, MD, Chattanooga

David J. Phillips, MD, Chattanooga
Mark T. Pollard, MD, Chattanooga
B.W. Ruffner Jr., MD, Chattanooga
David E. Ruiz, MD, Chattanooga
Nita W. Shumaker, MD, Hixson
Kirk A. Wilcox, MD, Chattanooga

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE

Eugene M. Finan, MD, Brownsville
David Villarreal, MD, Jackson

KNOXVILLE ACADEMY OF MEDICINE

Teri L. Hodges, MD, Knoxville
Philip B. Kellett, MD, Knoxville

MAURY COUNTY MEDICAL SOCIETY

James M. Fitts Jr., MD, Columbia

MONTGOMERY COUNTY MEDICAL SOCIETY

Charles P. Fitch, MD, Clarksville

NASHVILLE ACADEMY OF MEDICINE

Melvin D. Law Jr., MD, Nashville
John S. Pirolo, MD, Nashville
Eddie J. Reddick, MD, Nashville
Eugene J. Winter, MD, Nashville

NORTHWEST TENNESSEE ACADEMY OF MEDICINE

Soheil L. Hanna, MD, Dyersburg

PUTNAM COUNTY MEDICAL SOCIETY

Scott H. Keith, MD, Cookeville

RUTHERFORD COUNTY/STONES RIVER ACADEMY OF MEDICINE

Tina C. Gresham, MD, Murfreesboro

SCOTT COUNTY MEDICAL SOCIETY

Ahmad Idris, MD, Oneida
Asheesh Shipstone, MD, Huntsville

Personal News

G. Edward Hazlehurst, MD, Jackson, has been accepted as a member of the American College of Gastroenterology.

R. Henry Richards, MD, executive vice-president for medical affairs for King and Monarch Pharmaceuticals, Inc. in Bristol, has been named secretary of the American Academy of Pharmaceutical Physicians.

Robert L. Summitt, MD, dean of the College of Medicine at the University of Tennessee, Memphis, has been named the 1996 Pediatrician of the Year by the Tennessee Chapter of the American Academy of Pediatrics and the Tennessee Pediatric Society.

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during February, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Maysoon S. Ali, MD, Waverly
Subhi D. Ali, MD, Waverly
George F. Bale, MD, Memphis
Charles P. Bownds, MD, Pikeville
Edward L. Cattau Jr., MD, Memphis
Sung J. Chung, MD, Morristown
Larry C. Collins, MD, Cleveland
Joseph B. DeLozier III, MD, Nashville
Elise Denny, MD, Knoxville
Samuel H. Dillard Jr., MD, Brentwood
Morris L. Gavant, MD, Memphis
Melvin L. Goldin, MD, Memphis
Ralph C. Goodman, MD, Memphis
Larry G. Graham, MD, Kingsport
Harvey H. Grime, MD, Lebanon
Daniel P. Labrador Jr., MD, Chattanooga
John L. Law, MD, Knoxville
Jay F. Lewis II, MD, Chattanooga
James J. Madden Jr., MD, Nashville

Board of Medical Examiners

Minutes - February, 1996

Name: Helmut K. Harnisch, MD (Lewisburg)

Violation: Falsified application for national certification as a forensic examiner.

Action: License (which is currently suspended) continued on suspension for an additional year; must obtain continuing medical education in ethics; assessed a civil penalty of \$1,000.

Name: Harvey L. Nissman, MD (Virginia Beach, VA)

Violation: Disciplinary action in Virginia for conviction of a felony and subsequent actions in New York and Massachusetts.

Action: Per agreed order, license revoked.

ACTION OVERTURNED

TMA reported in the September 1993 issue of the *Journal* that the BME had found William D. Stewart, MD, in violation of the regulation against prescribing anorectic drugs. On Feb. 1, 1995, the Tennessee Court of Appeals overturned this decision and reversed the civil penalty of \$1,000, since the BME decision was in error.

Special Communication

Management of Prescribing With Emphasis on Addictive or Dependence-Producing Drugs Policy Statement of the Tennessee State Board of Medical Examiners

The Tennessee Board of Medical Examiners is charged by the General Assembly to protect the citizens of the State from harmful physician management. A significant number of physicians who are asked to appear before the Board are required to do so because of their lack of information about the management and responsibilities involved in prescribing controlled substances. Frequently, the inadvertent offender is a physician with a warm heart and a desire to relieve pain and misery, who is always pressed for time and finds himself or herself prescribing controlled drugs on demand over prolonged periods without adequate documentation. These are often for chronic ailments such as headache, arthritis, old injuries, chronic orthopedic problems, backache, and anxiety. (Terminal cancer pain management is not a consideration here.) The purpose of the Board of Medical Examiners in presenting the following information is to help licensed physicians in Tennessee consider and reevaluate their prescribing practice of controlled substances. Practicing physicians have often mentioned the abrupt education they received in their own prescribing patterns. Moreover, there have been many requests to the Board from physicians requesting detailed information on prescribing in certain specific situations.

It is not what you prescribe, but how well you manage the patient's care, and document that care in legible form, that is important.

The prescribing matters that come before the Board are almost always related to the prescription of controlled substances. We feel that a majority of instances where physicians have been disciplined by the Board for prescribing practices could have been avoided completely if they had followed the steps that are being outlined here.

To prevent any misunderstanding, it is necessary to state what the Board *does not* have.

It *does not* have a list of "bad" or "disallowed" drugs, except in certain circumstances, amphetamines, amphetamine-like substances and central nervous system stimulants. (See, Board of Medical Examiner Rule 0880-2-.14, a copy of which is available to you by contacting the Board's administrative office at 615/367-6231.) All formulary drugs, except as previously noted, are good if prescribed and administered when properly indicated. Conversely, all drugs are ineffective, dangerous, or even lethal when used inappropriately.

It *does not* have some magic formula for determining the dosage and duration of administration for any drug. These are aspects of prescribing that must be determined within the confines of the individual clinical case, and continued under proper monitoring. What is good for one patient may be insufficient or

fatal for another.

What the Board *does* have is the expectation that physicians will create a record that shows:

- Proper indication for the use of drug or other therapy;
- Monitoring of the patient where necessary;
- The patient's response to therapy based on follow-up visits; and
- A rationale for continuing or modifying the therapy.

Step One. First and foremost, before you prescribe anything, start with a diagnosis which is supported by history and physical findings, and by the results of any appropriate tests. Too many times a doctor is asked why he or she prescribed a particular drug, and the response is, "Because the patient has arthritis." Then the doctor is asked "How did you determine that?" and the answer is, "Because that's what the patient complained of." Nothing in the record or in the doctor's recollection supports the diagnosis except the patient's assertion. *Do a workup sufficient to support a diagnosis* including all necessary tests.

Step Two. Create a treatment plan which includes the use of appropriate non-addictive modalities, and make referrals to appropriate specialists, such as neurologists, orthopedists, psychiatrists, etc. The results of the referral should be included in the patient's chart.

Step Three. Before beginning a regimen of controlled drugs, make a determination through trial or through a documented history that *non-addictive modalities are not appropriate or they do not work*. A finding of intolerance or allergy to NSAIDs is one thing, but the assertion of the patient that, "Gosh, Doc, nothing seems to work like that Percodan stuff!" is quite another. Too many of the doctors the Board has seen have started a treatment program with powerful controlled substances without ever considering other forms of treatment.

Step Four. *Make sure you are not dealing with a drug-seeking patient.* If you know the patient, review the prescription records in the patient's chart and discuss the patient's chemical history before prescribing a controlled drug. If the patient is new or otherwise unknown to you, at a minimum obtain an oral drug history, and discuss chemical use and family chemical history with the patient.

Step Five. It is a good idea to obtain the informed consent of the patient before using a drug that has the potential to cause dependency problems. *Take the time to explain the relative risks and benefits of the drug and record in the chart the fact that this was done.* When embarking on what appears to be the long-term use of a potentially addictive substance, it may be wise to hold a family conference and explain the relative risks of dependency or addiction and what that may mean to the patient and to the patient's family. Refusal of the patient to permit a family conference may be significant information.

Step Six. Maintain regular monitoring of the patient, including frequent physical monitoring. If the regimen is for a prolonged drug use, it is very important to monitor the patient for the root condition which necessitates the drug *and* for the side effects of the drug itself. This is true no matter what type of controlled substance is used or what schedule it belongs to. Also, remember

The above policy was taken almost verbatim from the practice statement issued by the Board of Medical Examiners of the State of North Carolina in February of 1991 to all its licensees. We express our appreciation to them, and the Minnesota Board of Medical Examiners who originally distributed this information in 1990, and acknowledge the authorship by those two Board of this nine step process.

that with certain conditions, drug holidays are appropriate. This allows you to check to see whether the original symptoms recur when the drug is not given—indicating a continuing legitimate need for the drug or whether withdrawal symptoms occur—indicating drug dependence.

Step Seven. Make sure *you* are in control of the supply of the drug. To do this, at a minimum you must keep detailed records of the type, dose, and amount of the drug prescribed. You must also monitor, record, and personally control all refills. Do not authorize your office personnel to refill prescriptions without consulting you. *One good way to accomplish this is to require the patient to return to obtain refill authorization, at least part of the time.* Records of the cumulative dosage and average daily dosage are especially valuable. A thumbnail sketch of three hypothetical cases will illustrate our point here. In the first case, a physician prescribes Tussionex to a patient for approximately five years for a cumulative dosage of nineteen and one half gallons. In the second case, a physician prescribes Tylenol No. 3 to a patient for slightly more than a year at the average daily rate of 30 per day! The third case is very similar, except that it was Tylenol No. 4 at the rate of 20 per day. Some quick observations:

- No physician who was aware of that kind of prescribing would have continued with it.
- Few, if any, patients could have been consuming that much Tylenol with codeine. In all likelihood, they were reselling it.

Another important part of controlling the supply of drugs is to check on whether the patient is obtaining drugs from other physicians. Checking with pharmacies and pharmacy chains and other health care providers may tell you whether a patient is obtaining extra drugs or the patient is doctor shopping. If you are aware it is occurring, contact other physicians and health professionals in your area.

Step Eight. Maintaining regular contact with the patient's family is a valuable source of information on the patient's response to the therapy regimen, and may be much more accurate and objective than feedback from the patient alone.

The family is a much better source of information on behavioral changes, especially dysfunctional behavior, than is the patient. Dysfunctional changes may be observable when the patient is taking the drug, or when the drug is withdrawn. These changes, at either time, may be a symptom of dependency or addiction.

The family is also a good source of information on whether the patient is obtaining drugs from other sources, or is self-medicating with other drugs or alcohol.

Step Nine. To reiterate, one of the most frequent problems faced by a physician when he or she comes before the Board or other outside review bodies is *inadequate records*. It is entirely possible that the doctor did everything correctly in managing a case, but without records which reflect all the steps that went into the process, the job of demonstrating it to any outside reviewer becomes many times more difficult. Luckily, this is a problem which is solvable.

Adopted by the Board of Medical Examiners
on this the 19th day of September, 1995.

Oscar M. McCallum, M.D., President
Tennessee Board of Medical Examiners

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

Special Conferences/Seminars

Detailed brochures for the following courses are available. In some cases, registration numbers are limited.

- | | |
|-------------|--|
| May 16-19 | 13th Family Medicine/Primary Care Update |
| May 23-25 | 20th Sonography Symposium |
| June 28-29 | Laryngeal Video Endoscopy Workshop |
| July 15-19 | Contemporary Clinical Neurology—Hilton Head Isl., S.C. |
| Aug. 8-9 | Endoscopic Sinus Surgery and Revision Surgery Workshop |
| Aug. 15-16 | 1st Clinical Oncology Symposium |
| Sept. 25-28 | Pulmonary/Critical Care Medicine—Destin, Fla. |
| Oct. 18-19 | Laryngeal Video Endoscopy Workshop |
| Nov. 13-16 | 2nd Neonatology Symposium—Asheville, N.C. |
| Dec. 6-7 | 22nd High Risk Obstetrics Seminar |

For information contact Division of CME, Vanderbilt University School of Medicine, D-8211 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

Continuing Education Schedule

Memphis

- | | |
|-------------|---|
| May 8-12 | Perinatal Social Work |
| June 6-7 | General Surgery Update |
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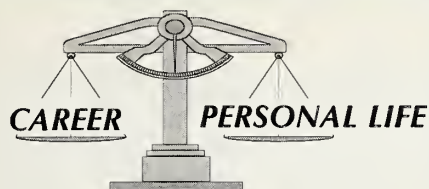
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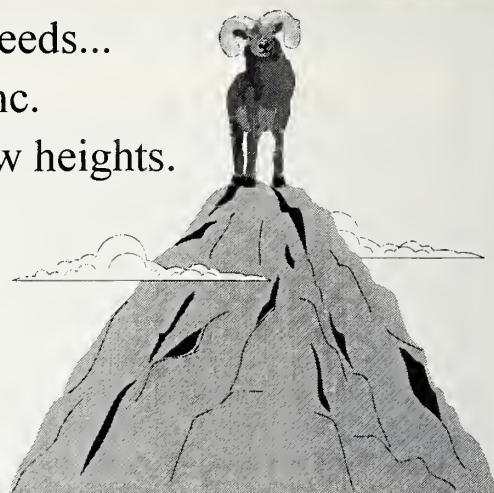
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List of Advertisers

Carolyn Avery & Associates, Inc.	175
Dodson Insurance Group	170
Emergency Care Specialists	176
First Tennessee Bank	146
Jeremy Cay, Edisto Island	148
Mental Healthcare Management	176
Naval Reserve	175
Patriot Investment Management	175
Rural Health Services Consortium	176
State Volunteer Mutual Insurance Company	180
Team Health	175, 176
TN Dept. of Health	176
TN Dept. of Mental Health/Mental Retardation	179
The TMA Association Insurance Agency, Inc.	178
U.S. Air Force Reserve	163

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Richard M. Pearson, MD

A Paradigm for Healing

How often recently, when dealing with some managed care issue, or insurance company, or Medicare, have you said to yourself, "This problem is nonsensical; this issue defies description; I've never dealt with anything like this before"? The reason you feel this way is because nothing in your medical training or experience has prepared you to analyze such issues or confront them in a positive fashion.

Physicians are coping with these problems in numerous ways: trying to educate themselves without knowing exactly what to learn, expressing frustration and anger without targeting, adding new staff without planning, forming groups without bonding, sometimes quitting practice without hope. For those hanging on, the frustrations and problems appear to grow almost daily, and solutions appear increasingly unlikely.

Imagine that you leave your office one evening, with plans to return to work the next morning. You leave your office in the state you want. The physical layout meets the needs of your patients, your staff, and yourself. Your staff is selected, trained, and encouraged by you. You have a good telephone system, and the doors to your office are accessible and open easily.

When you return the next morning almost everything has changed. There is a notice on your door excluding all your patients who belong to the HMO that dropped you last week. Later the HMO will want you to copy all their records and transfer them to new "providers," all at your expense. Just inside your door is a turnstile, where patients must stop until their insurance company has approved the visit. Further inside you find that the space for handling paperwork has been greatly enlarged and the space for treating patients has been contracted. Various barriers have been set up to keep you from doing certain things for certain patients. All the rules are available in stacks of manuals in the business office, or you can call long distance and be put on hold. The staff that should help you care for patients is preoccupied with getting tests and treatments approved. Representatives from three different pathology labs (each designated by a different carrier) are stomping down the halls demanding their specimens, documentation, and five-digit ICD-9 codes. You no longer recognize your office. Both its shape and its character have changed.

Now the bad news. Your office and mine aren't going to return to normal tomorrow. It's only going to get worse. The stress will grow, and coping will be ever more difficult. Therefore, if we are going to continue caring for our patients, we must simultaneously care for ourselves. This isn't a selfish attitude; it's a healthy attitude. How often do you feel that your ethics won't allow you to close your doors, but present economics and hassle won't let you keep them open. Our difficulty in confronting the present health care chaos is not a personal or professional failure, but a personal and professional crisis. We all must cope first with our individual internal crisis successfully if we are ever to cope with the external crisis. We must see ourselves and our practice "world" differently. Our vision must be shaped and defined by what is within us rather than what is without.

What is "without" is confusing, intimidating, unfair, unreasonable, unfeeling. Our personal and professional lives must not become a reflection of the trouble that lies outside us, but rather be the source of an inner light that illuminates our path, dismisses the shadows, and highlights what is best about being a physician. We must define ourselves, not be defined by others. We must define our profession, not allow it to be divided and diminished. We must define our

future, not allow our future to be defined for us by governmental ignorance and corporate arrogance and greed. Above all, we must act from within, not react from without.

The pattern or model we all have internally for our personal and professional lives is called a paradigm. It is our frame of reference. It is the projection of our thoughts and feelings onto the world around us. All that we encounter and accomplish must be accommodated in our paradigm. What happens when we encounter something, such as our chaotic future, that won't fit into our paradigm? We either change the shape of chaos (we can't!) or we change our paradigm (we must!).

Our current vision is too narrow, too limiting. We physicians tend to define ourselves as only clinicians, or only business people, or somewhere between the two. We feel more comfortable in the clinical realm because therein lies our calling, our training, and our experience. Most of us lack formal business training or extensive business experience. Most don't work daily with budgets, projections, finance, personnel management, or operations. We fret over our limits. We forget that our lives, like our universe, have more than two dimensions. On the inside we are real people, not just clinical or business entities.

Most of us studied Euclidean geometry: points, lines, planes, spheres—we understand this. Most of us did not study the new geometry of fractals, mathematical building blocks that can be infinitely manipulated to create new shapes for computer modeling, advanced mathematics, graphics, and imaging. Fractals, unlike points and lines, can neither be understood nor accommodated in Euclidean geometry. Our fractal future cannot be understood or accommodated by our past traditional paradigm. We have to have a new vision, a new paradigm. That new paradigm must be shaped from within by personal and professional development.

Your new paradigm must allow you to be a whole person again. It must allow you to enjoy living and giving while empowering you to cope effectively with your personal and professional stress. It must accompany you into the organizations you deal with daily. It must embolden and empower you to change those organizations so that the right things are easy to do, so that you receive formal training to learn and grow, so that your needs are met, so that your potential is realized.

How to build it? It will take a lifetime. Start today with yourself, your family. Meet your needs and theirs. Renew your spirit. Enrich your life with information, guidance, and support. Extend it to your professional life. Maintain and renew your values and ethics. Talk and work and empathize with your colleagues. Support your professional associations with your time and efforts while leaning on their strengths. Expand the process to your community. Do good. Make a difference.

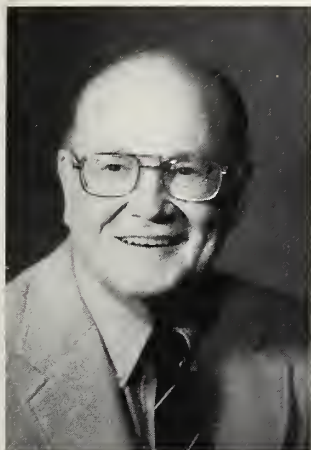
Now, more than ever, "Physician, heal thyself." □

R. Pearson MD

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John B. Thomison, MD

Tennessee Bicentennial

According to my best information at this point, June 1 is Tennessee Statehood Day, the date being the one on which in 1796 Tennessee became the 16th state in the Union. This event is memorialized forever, or at least forever figuratively speaking, by the three stars that grace our state flag, which signify that Tennessee became the third state to be added to the original 13, and not that Tennessee is in reality three states, as popular myth would have it, even though we sometimes act as if we are. I guess it is fitting and proper that we make mention of that celebration in the June 1996 issue of this publication, as in so doing the *Journal* joins the other celebrants of the occasion.

Having become weary of birthdays, I have to confess to being a bit blasé about all such celebrations, individual or corporate, and I gather that such an attitude is not uncommon. The Centennial celebration of our statehood, which left Nashville with the Centennial Park and the Parthenon, nearly didn't get off the ground, and actually was a year late happening. The current one started out with big plans nearly ten years ago, from which it continued dwindling, suffering from a lot of political wrangling. Its legacy will be the Bicentennial Mall, which unlike its predecessor, just might be finished by Statehood Day this year.

Everything has to start somewhere, and by custom in this country states quite naturally look to their statehood day as the very beginning, even though in actuality it may not be that at all. It is, one must admit, a very good place to start, as the *very very* beginning is shrouded in the dim, dark, or at least foggy, distant past, before the coming of the Indian. I have to digress a moment to discuss the penchant for referring to the Indian these days as a Native American. He's no such thing, despite his having gotten here first. This hemisphere was devoid of human inhabitants for eons before some intrepid bands from Mongolia traversed the Bering Straits perhaps 40,000 or so years ago during the last ice age. The Indian is no more native American than he is Indian, so-called because Columbus thought India was where he had landed. But Indian has priority of usage, and I'm sticking with it. Next in line came the Spanish conquistador Hernando De Soto and his band, the first Europeans, and I should guess non-Indians, to wander about what is now Tennessee. One could start with that year, which was 1541, and be a couple of hundred of years older. I'm not pushing it, understand. Just mentioning it.

Both France and England claimed parts of the territory during the 17th and 18th centuries, but in 1763 the French relinquished all claims to lands east of the Mississippi. This stimulated the English settlers to establish permanent European settlements. A lot of folks, in East Tennessee, especially, think John Sevier and James Robertson blew it in not seceding from North Carolina when under their leadership the settlers in a few isolated centers organized themselves in 1772 into the Watauga Association for protection and administration of justice, since North Carolina was doing neither. But the American Revolution started in a few years, and in characteristic form the Tennesseans-to-be, led by Sevier and Isaac Shelby, Robertson having gone West in 1799 to found Nashville, saved the new nation at the Battle of King's Mountain in October 1780, by preventing the uniting of two British forces, and thereby forcing the surrender of General Cornwallis at Yorktown.

Then there was the lost State of Franklin. Following the Revolution there were numerous skirmishes with the Cherokee Indians for control of the territory. The State of Franklin was formed in 1784 in eastern Tennessee out of land ceded by North Carolina to the federal government, but North Carolina refused to recognize the new state, and John Sevier, Franklin's gover-

nor, was arrested in 1788, and the new state collapsed. North Carolina again ceded its western territory to the United States in 1789, and in 1790 President Washington commissioned William Blount governor of all U.S. territory south of the Ohio River. On June 1, 1796, Tennessee became the 16th state, with Sevier as its first governor. While this may not, then, be the *very very* beginning, it is the next best thing, and is what was chosen around 1890 to be the object of celebration.

And so it is that 1996 is the Bicentennial Year, and *the day* is June 1. Hip-hip *Hooray*, and Whoopee.

Hello, Choir! Are You Listening?

How shall they believe on Him of whom they have not heard,

And how shall they hear without a preacher? . . .

And I said, Here am I; send me.

The Holy Bible, Isaiah

If it ain't broke, don't fix it.

Aphorism (I think)

Once when I was younger and knew less than I do now but thought I knew a whole lot more, I berated our preacher for preaching platitudes. "After all," I said, "Everybody that's here already knows all that. You're just preaching to the choir. Tell us instead something we don't already know," I said, or words less harsh but to that effect. His response was, "How do you know only the choir is here? And how do you know everyone in the choir knows all that? One never knows who may be listening." I was unconvinced by the now-obvious wisdom of his words. Here's a man, I thought, who has a message he just has to deliver. And so he does. It was not until I started writing editorials that I began to appreciate how preachers must feel about the timeliness, even timelessness, of their messages, and how correct he was to deliver the one he was given, despite my criticism, which didn't mean, as it shouldn't have meant, much to him.

No question about it. Things are radically wrong with the way things are going these days. The corollary to the aphorism quoted above is that if things *are* broke, fix 'em! As I began reading through Dr. Pearson's message in this issue, I thought, "Aha! That's the ticket." And then I began to get the old "been there, done that" feeling—a sense of frustration in knowing what he was getting at without having a clue as to how he expected his readers to go about getting there. Exhortations are great for building enthusiasm, but without directions, frustration soon sets in. Like the Bible itself, which contains one exhortation after another, preachers of the Gospel at least have the edge of empowerment by God's Holy Spirit to accomplish their ends, both within themselves and for their hearers. Dr. Pearson kept me hanging there in suspense in the best editorial tradition until the bitter end, when he tossed out the bone: Stick together! Join your professional associations! Get active!

Nice going, Richard. But how? And anyhow, nearly everybody who would be reading this almost certainly is in the choir, so to speak. I still had that old feeling of being a bit at loose ends, just sort of still hanging there, when what to my wondering eyes should appear but an article on capitation by Mo Kirtane, a nuts and bolts type do-it-yourselfer with explicit instructions for adjusting your paradigm to cope with the current changes in the practice climate. "What a matchup!" I thought. First, Dr. Pearson's President's Comments, then the editorial that I would write calling your attention to that winning combination, and then the nuts and bolts article and, *Voila!* The *Journal* is made, all handed to me for you on a silver salver. It may not be the whole cloth, but it sure makes for a good start.

But don't stop with reading about it. To carry the analogy of the Christian Gospel one step further, the Good Book says, "Be ye doers of the Word, and not hearers only." 'Nuff said!

Some Happy Thoughts

The year's at the spring, the day's at the morn;
Morning's at seven; the hillside's dew-pearled;
The lark's on the wing; the snail's on the thorn;
God's in His Heaven—all's right with the world!

Robert Browning
from "Pippa Passes"

I put together the first edition of this piece back shortly after the first of the year, when it would have wound up in the April issue of the *Journal*. (Please note that even though *Tennessee Medicine* is now the official name of this publication, I have here referred to it, as I shall continue to, as the *Journal*, as well as its abbreviation *JTMA*, both of which are still appropriate.) Having lately written a few scathing pieces, aimed at a variety of targets in the area of controlled medical practice, I was casting about for some more pleasant things to deliver myself of, but try as I might, the bile kept on flowing. It was not helped by the January weather, which was dreadful. When I started writing this piece the first time the sun was shining brightly, the temperature outside was not too low, and I had just come inside from the exhilarating two-mile walk that I take on most days. It brought to mind the little ditty that opens this piece as entirely appropriate to the occasion. Despite its being the dead of winter, it somehow seemed nevertheless full of life. As the weather soured later on during the day, though, and the dead again set in, so did my mood, and I gave the whole thing up as a bad job.

It was not helped, either, by the newspapers, which just wanted to talk that day about such things as the Houston Oilers and how the banks were picking up \$10M or so of unsold seats, a woman jumping off the L&C Tower, and Vanderbilt getting sued. Big front page picture of a great big once solid looking building with the window-lights blown out, all done up in plastic against the weather . . . IRA at it again in London. Big picture of man looking upward toward top of L&C Tower, where the action had been, with squad car in foreground, where the action now was. Then Section D fell out. There spread out (likely you will think that application of the term uncouth. So OK; go ahead and think that). Anyhow, there spread out over its front page was what I'm sure was meant to be a sexy photo of an attractive country-pop singer who was there because she had finally made the charts—deservedly, I'm sure. My mother, and likely some of my contemporaries—female ones, at least—would doubtless have thought *it* (the photo, not her making the charts) uncouth. I thought it was just tacky. I mean . . . a long stretch of shapely lower extremity (anatomically, the *leg* extends from the knee to the ankle. This was more than that—considerably more) protruding from a partly unbuttoned long skirt, to around mid-thigh, and shod in . . . *brogans*, yet? (Anyway, *pianos* have legs; women and girls have . . . shhhhhh! . . . *limbs*.) That probably calls for another definition, which the feminists for some reason seem to dislike. *Women* are female human beings older, sometimes considerably, depending on how they look, than you are. The rest of the female human beings are *girls*. None of them are *females*, since *female* is an adjective, not a noun. Contrariwise, despite persistent misuse by the media, *woman* is a noun, and not an adjective. But back to the brogans. Not much happy help there. In fact, none at all. To make matters worse, an ink blob obscured the girl's (cf. above) mouth and chin. Fortunately, a small closeup of her face at the top of page one showed me that Linda (for that was her name) is indeed a looker (a less than literate term that nonetheless is in the dictionary: *Slang*). In any case, that was not enough to engender much happy writing. Entertaining, maybe, but not happy.

I was at that time looking with some anticipation toward my retirement from the practice of medicine. The second time I tried out this piece, retirement had come closer upon me. *Retirement*, I thought. Now *there's* a real plus. Happy copy, here I come. But, I thought, if you want this to stay happy, don't try to explain the reasons for the anticipated *joi de vivre* and the present lack of it. (I was about to say "expected," but as George Burns observed when he was actually

even younger than I am now, he didn't even buy green bananas. So to say I *expect* it would only be tempting fate.) (A late Bulletin: George Burns has since died.) So I was *anticipating* the enjoyment. I think I took care of the reasons for its present absence in an editorial that I wrote a few months back, which was actually what precipitated the urge for happy copy. No more having to kowtow to whimsical corporate micromismanagement.

So now, in my third attempt, the year *is* at the spring, as the poet said, but the hillside is *not* dew-pearled, and so on. Another oft-quoted aphorism is that getting there is better than being there. I don't necessarily hold with that, since these days the actual travel is usually itself nothing to write home about, unless it is to be covered amply by expletives. This year, getting to spring, than which in most years there is nothing lovelier here in Tennessee, was a tribulation, and a late, prolonged, pre-spring deep-freeze took care of being there. It is all brown, with a little green grass stuck around. God is doubtless in His Heaven, but His world looks a little the worse for winter wear and tear.

As for being in retirement, I recognize, from having observed my retired peers, that not everything is peaches and cream there, either, though at the moment I'm not sure what will be missing except for the daily association with my friends, which of course is a lot. But my feelings of deprivation antedated my retirement, starting as it did at the time our operation was moved something over a year ago out of our comfortable, charming, homey old quarters into new, less hospitable ones. The work, which I used to enjoy, has become wearing and considerably less than enchanting. In short, drudgery. I decided that at my age I didn't have to put up with it, and so I wouldn't.

And thus, my retirement from the practice of Pathology has now set in. On the other hand, my retirement from editorship of the *Journal* has not, nor is it anticipated.

Yesterday's Easter sermon was entitled, "Angel on the Stone, Soldiers on the Ground," referring to the empty tomb, with an angel sitting on the stone that had sealed it, and the Roman guards lying prostrate before it "as dead men." I was reminded that though externals are important, some more burdensome and some more joyous than others, we assign a lot more to all of them than they deserve.

I was reminded also that God is indeed still in His Heaven. Whether or not all seems right with the world is our choice. If you decide there are things in it that need fixing, maybe He is looking to you to work at it, since ours are the only hands He has. □

BALLARD LECTURESHIP FUND ESTABLISHED

At the April 3 meeting of the Board of Directors of the Tennessee Alliance for Continuing Medical Education (TACME), the Board voted to establish the "Thomas K. Ballard, M.D. Lectureship Fund" in honor of Thomas K. Ballard, M.D., Jackson, for his many years of support of CME in Tennessee. Funds received will be used to financially support the keynote speaker at the TACME's Annual Conference on CME. Dr. Ballard originally suggested the development of the Annual Conference on CME which began in 1991, and which presently continues under the direction of the TACME.

Dr. Ballard is a past president of the Tennessee Academy of Family Physicians and received the TAFP's "Family Physician of the Year Award" in 1975. He is also a past president of the Tennessee Medical Association, and received the TMA's "Outstanding Physician of the Year Award" in 1987. He was honored by the TMA at the First Annual Conference on CME in 1991 for his CME efforts.

The TACME was founded in January 1993 to continually improve the quality and effectiveness of CME programs and systems in Tennessee for the purpose of enabling practicing physicians to continually improve the quality and effectiveness of patient care.

Donations are now being accepted. Your check should be made to the Tennessee Alliance for Continuing Medical Education, with a notation on your check that it is a donation to the "Thomas K. Ballard, M.D. Lectureship Fund." Checks can be mailed c/o the TAFP, 7003 Chadwick Drive, Suite 253, Brentwood, TN 37027. The TAFP will forward your check to the TACME.

Managed Care: Are Restrictive Provider Panels Out and Capitation In?

Mo Kirtane

Last year Kaiser Permanente, the granddaddy of all HMOs, announced its new policy to begin contracting with non-Kaiser physicians and hospitals. Kaiser, a staff model HMO, had relied exclusively on its staff physicians and its own hospitals and clinics to deliver care to its enrollees. Kaiser plans were mired in stalled growth since late 1980s. David Lawrence, MD, Kaiser's CEO, had candidly admitted that "Product innovation isn't our game. We aren't product maven. But in recent years there has been a steady drumbeat of companies telling us that they won't offer Kaiser to their employees or that they are dropping us because Kaiser restricts employees to Kaiser doctors and facilities."

As the physician community is painfully aware, initial development of managed care plans was characterized by insurer channeling of patients to low-cost physicians and hospitals, heavy-handed utilization management, and deselection/lockout of physicians. Many physicians overreacted to this perceived threat by selling their practices to hospitals and practice management companies. Others organized themselves by forming IPAs or joining group practices thinking that there was safety in larger numbers. The health care marketplace was in a state of flux trying to react to the new market forces. In the early 1990s two market forces began to have a dominant impact.

- Narrow provider panels were restrictive and consumers were increasingly unhappy about lack of choice in selection of physicians and hospitals.

- Concept of capitation allowed insurers to transfer risk to physicians and give them incentive to control utilization without stifling utilization review. Some west coast IPAs achieved utilization levels comparable to those found in closely managed groups (Fig. 1).

Major health plans in California were quick to adjust to the dynamics of the marketplace and began to offer plans with broader provider panels. Fig. 2 displays ratios of physi-

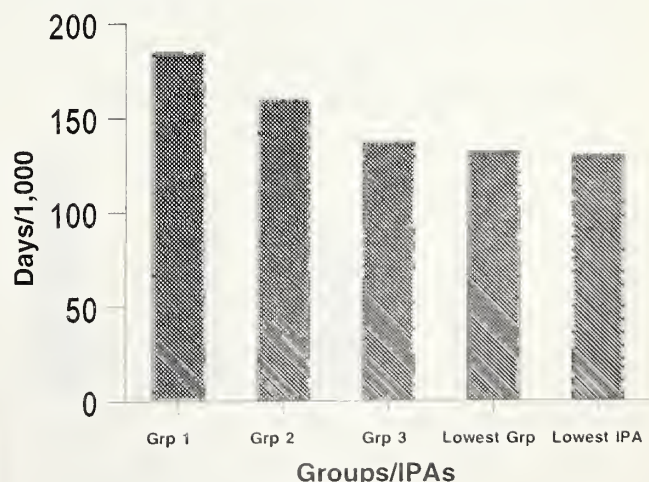
cians per 10,000 enrollees for some large health plans in California. There was a substantial broadening of physician panels from 1989 to 1994. In Sacramento some plans have as high as 86% of the available primary care physicians in the area included in the panel.

What are the implications of these developments for Tennessee physicians? Does it now mean that physicians no longer have to worry about losing access to patients? Of course not. The threat of getting locked out has perhaps diminished if these developments hold. With the oversupply of physicians in most urban markets, however, health plans can offer adequate access to enrollees without having to include all "willing providers."

As pointed out earlier, health care plans have accomplished their cost management objectives by realigning financial incentives of physicians through capitated arrangements. Physicians will need to worry about managing their costs as opposed to managing revenues if they want to stay in business.

FIGURE 1

Inpatient Utilization in California



Source: Advisory Board, Washington, D.C.

Mr. Kirtane, a former senior executive at St. Thomas Hospital, Nashville, is president of Franklin Healthcare Consulting of Franklin, Tenn.

It is my observation that Tennessee physicians are woefully unprepared to manage their practices under capitated arrangements, which is understandable since most of managed care in Tennessee so far involves discounted fee-for-service PPOs. Whether or not physicians agree with the concept of capitation, it is in their best interest to prepare themselves for it. Now is the time to size up your practice and at least identify the deficits and develop a plan of action to address them. At present very few practices rely on capitated revenues to any significant degree, and can afford to make a few mistakes to gain experience in taking care of capitation-covered lives. Following are suggestions that can be used as a checklist to assess your readiness to accept capitation.

- Do you know utilization rates for your current patients by CPT code, age, sex, payor, etc.? It is essential that you have a state-of-the-art computer system, because in the arena of capitation, information is money. In fee-for-service medicine, all you needed was a good billing and collection system. Remember that in a capitated system, there is *neither billing nor collection other than per visit co-payment!* A good computer system should minimally have the following features.

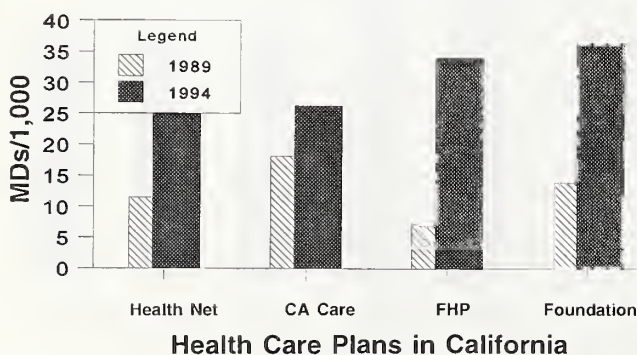
- ✓ It must be flexible enough to allow capture of information on user defined data elements. For example, you may want to track information on employers of your patients, which may not be a standard data element your system retains.

- ✓ It should provide for tracking of *costs* by CPT code.

- ✓ The most important feature is its capabilities as a *decision support system*. It must allow manipulation of data elements and formatting of reports through a user-friendly flexible report writer. In plain English, it means that you should be able to generate special reports based on your needs. For example, if a health care plan wants to offer separate capitation rates for various age groups, you should be able to analyze your practice experience by age cohorts to determine your current collections and costs in order to know if the rate offered is acceptable to you.

FIGURE 2

Ratio of MDs per 10,000 Enrollees



Source: National Directory of HMOs, Advisory Board

- Your mindset must change from managing revenue to managing costs. After this shift occurs, it will be easier for you to focus on costs, and realize that it is possible to make money under capitation by squeezing out unnecessary costs and improving the effectiveness of your practice.

- You must know your current costs, charges, and collections by CPT code to be able to accept or reject a capitation offer from a health care plan. If your current computer system does not readily provide this information, it would be worth the effort and money to generate this information on a one-time basis. It will allow you to develop a threshold for a minimum capitation offer by matching your collection rates with the historical utilization rates for potential enrollees that the insurer can provide you.

- In a capitated arrangement, a risk pool is set up by the hospital and the physician group that is funded by the "withholds" from the reimbursement for inpatient care. Based on the performance of the hospital and physicians in meeting the target inpatient utilization rates, money remaining in the risk pool at the end of the year is split 50:50 between the hospital and physicians. This payment to physicians can become substantial as the number of covered lives under contract increases. Is the hospital of your choice aggressive in managing costs? A hospital that can better support you in your efforts to reduce length of stay and utilization of ancillary services will be a superior economic partner. What are you doing to strengthen your relationship with such a hospital? Conversely, are you active and aggressive enough in leading/participating in the hospital-sponsored initiatives to reduce the cost of care?

- The flip side of the effect of the broadening of physician panels is that the patient has a wider choice, and can "deselect" you instead of the health care plan! You will keep the business (and generate new business) the old fashioned way: by earning it through providing patients reasonable access, delivering quality care, and maintaining patient satisfaction. To that end, are you measuring patient satisfaction in your office practice, and tracking the time between the patient's phone call for an appointment and the actual date of the appointment, to ensure reasonable access?

In summary, it is important for Tennessee physicians to understand that health care plans were able to open up provider panels and eliminate stringent utilization review by creating an incentive plan for physicians, i.e., capitation. Because of the success of the concept, it will no doubt spread to other parts of the country over time. It is crucial that physicians "tune up" their practices to accept capitation, and that they do so now, when capitation is not much of a force to reckon with in Tennessee. This would be a good opportunity to be in the driver's seat and proactively manage the change instead of reacting to it. It might even be fun not to be on your heels for a change! □

INDEX TO PROCEEDINGS

House of Delegates—161st Annual Meeting

Call to Order	194	Nominating Committee Appointments	195
Committee on Credentials	194	Outstanding Physician of the Year Award	211
Community Service Awards	212	Reference Committee Appointments	194
Distinguished Service Awards	211	Report of the Board of Trustees	206
Election of Officers	195	Report of the Chief Executive Officer	209
House of Delegates Composition	216	Report of the Judicial Council	207
Invocation	194	Report of the President	206
Minutes Approved 1995	194	Report of the Secretary-Treasurer	208

AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Bylaw Amendment No. 1-96—Organized Medical Staff Section	195
Bylaw Amendment No. 2-96—Deletion of Committee on Mental Health	196
Bylaw Amendment No. 3-96—Reformation of Division and Committee Structure in Coordination With Strategic Plan	196

RESOLUTIONS

No. 1-96	Reaffirmation of Resolution No. 2-89 (Out-of-State Pharmacies)	197
No. 2-96	Reaffirmation of Resolution No. 10-89 (Ban on Smoking in Public Places)	197
No. 3-96	Reaffirmation of Resolution No. 16-89 (Medicare Reimbursement, Geographical Differences)	197
No. 4-96	Reaffirmation of Resolution No. 22-89 (Consent Calendar)	197
No. 5-96	Reaffirmation of Resolution No. 23-89 and Consolidation with Resolution No. 30-93 (Hospital Medical Staff Bylaws)	198
No. 6-96	Reaffirmation of Resolution No. 25-89 (Pre-Admission Screening for Nursing Homes)	198
No. 7-96	Reaffirmation of Resolution No. 29-89 (Support of the Board of Medical Examiners)	198
No. 8-96	Reaffirmation of Resolution No. 8-89 (Diversion of Prescription Drugs)	199
No. 9-96	Reaffirmation and Modification of Resolution No. 1-89 (TMA Student Education Fund Assessment) and Resolution No. 1-90 (Dues to Fund TMA-SEF)	199
No. 10-96	Annual Component Society Report on Adoption of Peer Review Guidebook	199
No. 11-96	Commission on Office Laboratory Accreditation (COLA)	200
No. 12-96	Human Immunodeficiency Virus (HIV) Testing of All Pregnant Women	200
No. 13-96	Early Discharge of Mothers and Infants from the Hospital	200
No. 14-96	Affiliation With Nurse Practitioners	200
No. 15-96	Managed Care Gag Rules	200
No. 16-96	Physician's Role in Managed Care	201
No. 17-96	Utilization Review	201
No. 18-96	Evaluation of Managed Care Programs	202
No. 19-96	Outstanding Physician of the Year Award	202
No. 20-96	Modified Community Rating Insurance Plans	202
No. 21-96	Health Insurance Coverage Reform	202
No. 22-96	Increased Portability of Health Insurance	203
No. 23-96	Limiting Out-of-Pocket Expenses for Pre-Existing Conditions in Health Insurance	203
No. 24-96	Limitation of Pre-Existing Conditions Exclusions in Health Insurance	203
No. 25-96	Physician-Patient Advocacy in the TennCare Partners Program	203
No. 26-96	Freedom of Local Government Act	203
No. 27-96	Medicaid Class Action Lawsuit Against the Tobacco Industry	204
No. 28-96	Problems of the Rural Physician	204

Abstract of the Proceedings of the House of Delegates of the Tennessee Medical Association, Knoxville, Tennessee, April 11-14, 1996

Call to Order

The 161st Annual Meeting of the Tennessee Medical Association was conducted in Knoxville, Tennessee, April 11-14, 1996, with headquarters in the Hyatt Regency Hotel. The House of Delegates met initially at 2:00 PM, April 11, 1996, with Thurman L. Pedigo, MD, Nashville, presiding as speaker of the House.

Invocation

At the opening session, Thomas K. Ballard, MD, Jackson, gave the invocation: "Our Dear Heavenly Father, As we open our 161st Annual Meeting of the Tennessee Medical Association, we are here to carry out the business of our Association to the best of our ability. We ask thy blessings on this assembly—that we may be filled with knowledge and understanding to enable us to better care for the reason that we exist, that is our patients. Help us to be ever mindful that only we as physicians are true patient advocates. Help us to hone our skills and expand our knowledge for the betterment of patient care. Dear Father, we desire to be human extensions of the great physician—your son, our Lord Jesus Christ; in whose name we pray. Amen."

Report of the Committee on Credentials

Karen T. Rader, MD, Knoxville, chairman of the Committee on Credentials, reported there was a quorum present. The speaker declared the House was in session.

1995 Minutes Approved

The speaker announced that an abstract of the minutes of the last regular session of the House of Delegates was reproduced in the June 1995 issue of the *Journal of the Tennessee Medical Association*. It was moved and seconded that the abstracted minutes of the 1995 session of the House of Delegates be approved as published in the June 1995 issue of the *Journal*. The motion was adopted.

Reference Committees

The speaker announced the members of the reference committees to consider reports, resolutions, amendments, and all matters requiring action by the House of Delegates.

REFERENCE COMMITTEE ON CREDENTIALS

Karen T. Rader, MD, Knoxville, *Chairman*
George S. Flinn Jr., MD, Memphis
Mary M. Headrick, MD, Oak Ridge

REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BYLAWS

Charles E. Jordan III, MD, Cookeville, *Chairman*
Phil E. Orpet, MD, Memphis
L. Dow Strader, MD, Bristol

REFERENCE COMMITTEE A

George L. Eekles, MD, Murfreesboro, *Chairman*
Robert S. Niehols, MD, Crossville
Robert A. Vegors, MD, Jackson

REFERENCE COMMITTEE B

Starling C. Evins, MD, Franklin, *Chairman*
Robert R. Casey, MD, Oak Ridge
Evelyn B. Ogle, MD, Memphis

REFERENCE COMMITTEE C

L. Diane Allen, MD, Ooltewah, *Chairman*
Subhi D. Ali, MD, Waverly
Jerre M. Freeman, MD, Memphis

SPECIAL REFERENCE COMMITTEE ON FEDERATION REFORM

C. Eugene Jabbour, MD, Memphis, *Chairman*
David G. Gerkin, MD, Knoxville
Ann H. Price, MD, Nashville



The Honor Guard, Headquarters Troop, Support Squadron, 278th Armored Cavalry Regiment, present the flags to open the 161st TMA Annual Meeting as TMA officers Drs. Michael A. McAdoo, Richard M. Pearson, and David K. Garriott observe.

COMMITTEE TO ELECT THE OUTSTANDING PHYSICIAN OF THE YEAR

Charles Ed Allen, MD, Johnson City, *Chairman*
Charles W. White, MD, Lexington
Virgil H. Crowder Jr., MD, Lawrenceburg

Nominating Committees

As required in the Bylaws, the Board of Trustees appointed a Nominating Committee with representatives from each of the three grand divisions of the state. The speaker announced the committee members.

EAST TENNESSEE

Charles Ed Allen, MD, Johnson City
Clark E. Julius, MD, Knoxville
John W. McCravey, MD, Chattanooga

MIDDLE TENNESSEE

Reuben A. Bueno, MD, Nashville
Fred Ralston Jr., MD, Fayetteville
Randall Gary Samples, MD, Cookeville

WEST TENNESSEE

John W. Hale, MD, Union City
Charles W. White, MD, Lexington
Jesse C. Woodall Jr., MD, Memphis

ELECTION BY HOUSE OF DELEGATES

April 11, 1996

The preliminary report of the Nominating Committee was presented in the first session of the House of Delegates on Thursday, April 11, 1996. The final report of the Nominating Committee was presented on Sunday, April 14, 1996 at the closing session of the House. Nominees submitted by the committee were voted upon individually, and in each instance the speaker called for additional nominations from the floor. The following were elected.

President-Elect—R. Benton Adkins, MD, Nashville
Speaker—Robert D. Kirkpatrick, MD, Memphis
Vice-Speaker—Sam J. Williams III, MD, Chattanooga
Vice-President (East Tennessee)

John J. Ingram III, MD, Maryville
Vice-President (Middle Tennessee)

Subhi D. Ali, MD, Waverly
Vice-President (West Tennessee)

Neal S. Beckford, MD, Memphis
AMA Delegate (East Tennessee)

Charles Ed Allen, MD, Johnson City
(January 1, 1997-December 31, 1998)

AMA Alternate Delegate (East Tennessee)
David G. Gerkin, MD, Knoxville
(January 1, 1997-December 31, 1998)

AMA Delegate (East Tennessee)
Robert E. Bowers, MD, Chattanooga
(January 1, 1997-December 31, 1998)

AMA Alternate Delegate (East Tennessee)
John R. Nelson Jr., MD, Knoxville
(January 1, 1997-December 31, 1998)

AMA Delegate (West Tennessee)
Hugh Francis Jr., MD, Memphis
(January 1, 1997-December 31, 1998)

AMA Alternate Delegate (West Tennessee)
Michael A. McAdoo, MD, Milan
(January 1, 1996-December 31, 1998)—filling
unexpired term of Dr. James Chris Fleming

AMA Delegate (State-at-Large)

Francis W. Gluck, MD, Nashville
(January 1, 1997-December 31, 1998)

AMA Alternate Delegate (State-at-Large)
Robert C. Patton, MD, Kingsport
(January 1, 1997-December 31, 1998)

AMA Delegate (State-at-Large)
James Chris Fleming, MD, Memphis
(January 1, 1996-December 31, 1997)

AMA Alternate Delegate (State-at-Large)
Donald B. Franklin Jr., MD, Chattanooga
(January 1, 1996-December 31, 1997)

AMA Young Physician Section Delegate
John W. Hale, MD, Union City
(April 1996-April 1997)

AMA Young Physician Section Delegate
Steven G. Flatt, MD, Cookeville
(April 1996-April 1997)

AMA Young Physician Section Alternate Delegate
Mark David Patterson, MD, Greeneville
(April 1996-April 1997)

AMA Young Physician Section Alternate Delegate
Tara L. Sturdivant, MD, Knoxville
(April 1996-April 1997)

TRUSTEES

Middle Tennessee:

Joel R. Locke, MD, Franklin (1999)

West Tennessee:

Jesse C. Woodall Jr., MD, Memphis (1999)

COUNCILORS

First District—Burgin E. Dossett Jr., MD (1998)

Third District—Donna K. Hobgood, MD (1998)

Fifth District—Theresa T. Morrison, MD (1998)

Seventh District—Malcolm A. Cox, MD (1998)

Ninth District—Kenneth R. Maloney, MD (1998)

THE ABOVE WERE ELECTED BY THE HOUSE OF DELEGATES

Constitution and Bylaws Amendments

The speaker reported that there were three amendments to the Bylaws to be considered at this session by the House.

The proposed amendments to the Bylaws are shown below, with proposed new language shown in **boldface** type and material to be deleted shown in *italics* and enclosed in brackets.

AMENDMENTS TO THE BYLAWS

BYLAW AMENDMENT NO. 1-96

Organized Medical Staff Section

Whereas, For a few years, the Tennessee Medical Association (TMA) Hospital Medical Staff Section was active, culminating in its 1988 publication and distribution of TMA's Model Medical Staff Bylaws; and

Whereas, The Section provided the TMA membership with an independent voice that advocated, among other things, for the rights of medical staffs to self-credential and thereby assure high-quality health care in hospital settings without lay interference from hospital administrative interests; and

Whereas, The activity of the Section waned due to overlap of functions of several TMA committees; and

Whereas, There is renewed interest within the TMA membership to revive the section and reorganize it to cover medical staff issues, not only in traditional hospital settings, but within integrated delivery systems and other risk-bearing entities. Now, therefore, be it

RESOLVED, That Bylaw Chapter III, Section 12 be amended by deletion and insertion as follows:

Sec. 12. There shall be an [Hospital] **Organized Medical Staff** Section to provide representation **within the structure of the Association** for the interests of [hospital] medical staffs **in hospitals and integrated health delivery systems** [within the structure of the Association]. The medical staff of each [Joint Commission on Accreditation of Healthcare Organizations approved] hospital and **integrated health delivery system** in the state shall be entitled to [one] representati[ve]on in the section. All representatives must be members of the Association. The [Hospital] **Organized Medical Staff** Section shall be organized under a governing body **with appropriate bylaws approved by the Tennessee Medical Association Board of Trustees** and shall elect one delegate to represent it in the House of Delegates of the Association.

REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BYLAWS—*recommended adoption of Bylaw Amendment No. 1-96.*

ACTION: **ADOPTED**

BYLAW AMENDMENT NO. 2-96

Deletion of Committee on Mental Health

Whereas, The Committee on Mental Health for several years provided the Tennessee Medical Association with important service and representation in the public arena for its mission; and

Whereas, the committee has not had reason to meet for some time, and its role can now be filled more appropriately, from time to time, by the Board of Trustees appointing a task force to meet for that specific purpose with a short term project or goal. Now, therefore be it

RESOLVED, That Bylaw Chapter VII, Section 3 be amended by deletion as follows:

Sec. 3. Division on Scientific Services - This division shall be composed of the following special committees: a Committee on Emergency Medical Services; [a Committee on Mental Health;] a Geriatrics and Long Term Care Committee; and a Committee on Maternal and Child Care.

REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BYLAWS—*recommended adoption of Bylaw Amendment No. 2-96.*

ACTION: **ADOPTED**

BYLAW AMENDMENT NO. 3-96

Reformation of Division and Committee Structure in Coordination With Strategic Plan

Whereas, In June 1995, the Tennessee Medical Association (TMA) Board of Trustees (Board) began studying and preparing a long range plan for the TMA and finalized the plan after several

months of work during its January 1996 meeting; and

Whereas, TMA's Long Range Plan acknowledges that physicians face a radically changing practice environment, fierce economic pressures to control treatment costs, and business influences that seek to refocus physicians' concentration away from patient care and toward management and marketing issues; and

Whereas, Through the planning process, the Board learned from several regional physician focus groups that many physicians are struggling to compete with hospitals and other large integrated entities for ever more scarce health care dollars and that some of those physicians are seeking either to sell their practices or are consolidating from solo or small practices to large physician groups as a means of competing; and

Whereas, As the TMA moves ahead through 1996, 1997, and beyond, it must provide members with independent leadership, advocacy, and evaluative tools which account for current environmental and market factors so that physicians may respond proactively to the changing practice environment, governmental and regulatory influences, and the evolving relationship between physicians and their patients; and

Whereas, Unless TMA maintains, on behalf of its members, a vital, independent, consistent, credible, and strong presence amidst the changing health care market and regulatory arena, and articulates a meaningful vision for all physicians, no matter their age, sex, minority status, or geographic location in Tennessee, then TMA will be unable to stem the coming fragmentation of the medical community and polarization of physicians; and

Whereas, TMA's Bylaws should provide a clear mission and a corporate vehicle for the realization of TMA's Long Range Plan goals, including a restructuring of TMA's five divisions and related committees so that member physicians are empowered to more efficiently and cost-effectively lead and represent TMA's 6,800 members in light of their patient care objectives; and

Whereas, The TMA Committee on Constitution and Bylaws undertook large-scale changes to TMA's Constitution and Bylaws following passage of Resolution No. 25-92, but did so without the substantial benefit of a long range plan or similar focus; therefore, further changes are necessary; and

Whereas, TMA's Bylaws should enable the TMA to provide quality service that demonstrates value to TMA members in return for their membership investment, and which will allow TMA to provide member services in an operational and organizational manner that is professional, efficient, effective, responsive, and financially strong; and

Whereas, Certain TMA committees' agenda and work, often transient or seasonal in nature, could be best accomplished by shifting them from formal demarcation in the Bylaws to the administrative auspices of the Board; and

Whereas, The TMA Bylaws should be flexible and should not detail in minutiae the specific concerns and work of each standing committee; those details should be left to the Board, in consultation with committee chairs, to define committee direction in concert with the strategic plan. Now, therefore be it

RESOLVED, That, in order to allow the business of the Tennessee Medical Association (TMA) to become more efficient and flexible, any and all references in the TMA Bylaws concerning TMA standing and special committees and divisions are hereby deleted and such committees and divisions be shifted to fall directly under the administrative auspices of the TMA Board of Trustees for oversight direction in compliance with the TMA Strategic Plan.

REFERENCE COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BYLAWS—*recommended adoption of Bylaw Amendment No. 3-96.*

ACTION: **ADOPTED**

Resolutions

The following resolutions were adopted by unanimous consent during the opening session of the House of Delegates.

RESOLUTION NO. 1-96

Reaffirmation of Resolution No. 2-89 (Out-of-State Pharmacies)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, Resolution No. 2-89 called upon the Tennessee Medical Association (TMA) to educate its members and the business community that Tennessee law required that out-of-state, mail order pharmacies be licensed by the Tennessee Board of Pharmacy; and

Whereas, Although the pharmacy licensing law requires such registration, the Tennessee Board of Pharmacy still encounters out-of-state pharmacies that resist formal Tennessee licensure; and

Whereas, Since there still is such resistance to protective regulation, TMA ought to reaffirm its policy that the licensing of out-of-state, mail order pharmacies is sound public policy. Now, therefore be it

RESOLVED, That the Tennessee Medical Association policy continue to reflect that out-of-state, mail order pharmacies doing business in Tennessee should be required to register with the Board of Pharmacy as a means of protecting the public from unscrupulous and unregulated pharmacy business practices.

ACTION: ADOPTED

RESOLUTION NO. 2-96

Reaffirmation of Resolution No. 10-89 (Ban on Smoking in Public Places)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, The Tennessee Medical Association (TMA) House of Delegates has adopted a resolution recommending a ban on the sale and use of tobacco products in Tennessee hospitals; and

Whereas, The TMA House of Delegates has adopted a resolution continuing a no smoking policy for meetings of the House of Delegates and scientific sessions and in support of the efforts of the American Medical Association to achieve a ban of all advertising and promotion of tobacco products; and

Whereas, The TMA House of Delegates, in Resolution No. 10-89, called for a ban on smoking in public places; and

Whereas, It is incumbent upon the physicians of Tennessee to take a leadership role in encouraging individuals to refrain from using tobacco and tobacco products. Now, therefore be it

RESOLVED, That the Tennessee Medical Association be a leader in anti-smoking activities and continue its efforts to encourage the General Assembly and the executive branch of Tennessee state government to prohibit smoking in all state buildings and facilities and in all public gathering places, such as theaters, schools, hospitals, outpatient clinics, public health department clinics, and public transportation vehicles.

ACTION: ADOPTED

RESOLUTION NO. 3-96

Reaffirmation of Resolution No. 16-89 (Medicare Reimbursement, Geographical Differences)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, Medicare currently considers a single geographic unit in terms of calculating reimbursement; and

Whereas, A wide regional disparity in Medicare reimbursement for equivalent services adversely influences patient access to medical care and physician distribution; and

Whereas, The Tennessee Medical Association House of Delegates opposed urban-rural differences in Medicare reimbursement through the adoption of Resolution No. 16-89. Now, therefore but it

RESOLVED, That the Tennessee Medical Association continue to support the elimination of geographical differences in Medicare reimbursement.

ACTION: ADOPTED

RESOLUTION NO. 4-96

Reaffirmation of Resolution No. 22-89 (Consent Calendar)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

RESOLVED, That resolutions, which are unanimously supported in the reference committees, be allowed to be placed on a consent calendar at the discretion of the reference committee, and adopted as a group, without debate or comment, unless specific objection to one or all resolutions is voiced by a member of the House of Delegates at the time of presentation of consent calendar, a request may be made for removal of any item for debate or individual action without the need for a vote on permission to separate it from the other items; and be it further

RESOLVED, That reports of committees, at the discretion of the reference committees, also be placed on the consent calendar for filing; and be it further

RESOLVED, That Tennessee Medical Association Resolution No. 1-94 (Reaffirmation of Resolution No. 1-87; Sunset Provision for Resolutions) be hereby terminated; and be it further

RESOLVED, That the Board of Trustees of the Tennessee Medical Association make recommendations each year to the House of Delegates on any resolution which the Board of Trustees believes should be considered for termination or modification by the House of Delegates; and be it further

RESOLVED, That the Board of Trustees present to the House of Delegates each year for its consideration any resolution which has been active as Tennessee Medical Association policy for more than six years and which has not been reviewed and acted upon by the House of Delegates during that time period; and be it further

RESOLVED, That all policy passed by the House of Delegates be published annually in a Tennessee Medical Association Policy Compendium, to be approved prior to publication by the Board of Trustees.

ACTION: ADOPTED

RESOLUTION NO. 5-96

Reaffirmation of Resolution No. 23-89 and Consolidation with Resolution No. 30-93 (Hospital Medical Staff Bylaws)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, Resolution No. 23-89 called upon the Tennessee Medical Association's (TMA) Hospital Medical Staff Section to develop and distribute at cost to members upon request a model set of TMA-Hospital Medical Staff Bylaws; and

Whereas, In 1993, after the previous model set of bylaws had become obsolete, the House of Delegates passed Resolution No. 30-93 that called for the TMA to update and issue another set of model medical staff bylaws; and

Whereas, TMA's Legal Department issued the next draft during the fall of 1995 for review, editing, and approval by TMA's Hospital Medical Staff Section; and

Whereas, TMA policy should include a consolidation of Resolution No. 23-89 and Resolution No. 30-93. Now, therefore be it

RESOLVED, That the Tennessee Medical Association Hospital Medical Staff Section actively maintain an updated set of Model Medical Staff Bylaws for distribution upon request to TMA members at cost; and be it further

RESOLVED, That the Tennessee Medical Association Hospital Medical Staff Section's Model Medical Staff Bylaws be promoted strictly as a set of guidelines to assist medical staffs and hospital administrators in their review and development of working bylaws to govern their interactive and cooperative relationships.

ACTION: ADOPTED

RESOLUTION NO. 6-96

Reaffirmation of Resolution No. 25-89 (Pre-Admission Screening for Nursing Homes)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, The Tennessee Medical Association House of Delegates expressed opposition to such pre-admission screening in

Resolution No. 25-89; and

Whereas, The Omnibus Budget Reconciliation Act of 1987 (OBRA '87) prohibits a nursing facility from admitting any new resident who has a mental illness or mental retardation (or a related condition such as cerebral palsy and epilepsy) unless the Tennessee Department of Mental Health and Mental Retardation has determined that because of existing mental conditions and/or health problems, the person's primary need should not be met by a nursing facility; and

Whereas, The legislation also requires that individuals desiring admission to nursing homes be screened for mental illness and/or mental retardation; and

Whereas, Individuals who are not receiving or applying for TennCare benefits must also be screened. Now, therefore be it

RESOLVED, That the Tennessee Medical Association regard the screening for mental health prior to admission to a nursing home for persons not receiving or applying for TennCare benefits as an unwarranted infringement of their rights as citizens; and be it further

RESOLVED, That the Tennessee Medical Association is of the opinion that a patient's physician is the proper judge as to facility selection for those requiring inpatient health care.

ACTION: ADOPTED

RESOLUTION NO. 7-96

Reaffirmation of Resolution No. 28-89 (Support of the Board of Medical Examiners)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, Resolution No. 28-89 called upon the Tennessee Medical Association (TMA) to support the continuing work of the Board of Medical Examiners (BME) and to lobby the Tennessee General Assembly to secure the necessary funding, staffing, and computerization so that the BME could meet its statutory obligations; and

Whereas, In 1990, the TMA convened a BME Task Force that studied the licensing boards of sister states and issued a report with the recommendations for legislative changes to buttress the administrative work of the BME, including expanding the BME so that it could conduct business with three separate panels; and



Dr. Robert D. Kirkpatrick (left), newly elected Speaker of the House of Delegates, presents a plaque to retiring Speaker Dr. Thurman L. Pedigo in recognition of his six years of service to the House. TMA president Robert E. Bowers and Board Chairman Charles T. Womack look on.

Whereas, Since the Task Force issued its report, the TMA's Committee on Legislation has successfully pursued passage of substantial statutory amendments that have provided the BME with increased membership, administrative support, and regulatory effectiveness; and

Whereas, TMA policy should continue to reflect the Association's strong support for the BME's ongoing work in protecting the public. Now, therefore be it

RESOLVED, That the Tennessee Medical Association continue to provide appropriate professional, administrative, and legislative support for the Tennessee Board of Medical Examiner's ongoing work in policing the medical profession and protecting the public.

ACTION: ADOPTED

RESOLUTION NO. 8-96

Reaffirmation of Resolution No. 8-89 (Diversion of Prescription Drugs)

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, Resolution No. 8-89 called for the State Board of Medical Examiners to continue its efforts to investigate and discipline physicians who are involved in illegal prescribing or dispensing of prescription drugs; and

Whereas, There continues to be problems across the state with physicians involved in illegal prescribing or dispensing of prescription drugs. Now, be it therefore

RESOLVED, That the Tennessee Medical Association reaffirm its policy urging that the State Board of Medical Examiners continue its efforts to investigate and discipline those physicians who are involved in illegal prescribing or dispensing of prescription drugs.

ACTION: ADOPTED

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The reference committees have the option of recommending a resolution for adoption or rejection, for adoption as amended or substituted, for referral, or for no action. The resolutions that follow are in the form in which they were **adopted, not adopted, or referred** by the House of Delegates.

RESOLUTION NO. 9-96

Reaffirmation and Modification of Resolution No. 1-89 (TMA Student Education Fund Assessment) and Resolution No. 1-90 (Dues to Fund TMA-SEF)

CHARLES ED ALLEN, MD, CHAIRMAN
TMA-STUDENT EDUCATION FUND

Whereas, In January 1995, the Tennessee Medical Association (TMA) Board of Trustees reaffirmed by resolution TMA's historical role as the contribution collections avenue for member physician donations to the TMA-Student Education Fund (SEF) and thereby communicated to the SEF Board of Directors TMA's strong commitment to irrevocably continue this contractual role for the benefit of present and future medical students and all Tennesseans who benefit from highly educated physicians; and

Whereas, Funding for the TMA-SEF since 1981 has come from TMA physician contributions authorized by Resolution No. 1-89 and 1-90, and is currently earmarked in the amount totaling \$25 per

year; and

Whereas, The excellent management and loan administration by the SEF Board of Directors and TMA staff has resulted in a program with less than a 1% default rate, which has put the program on sound financial footing; and

Whereas, Combining the two funding policy resolutions would continue a level of funding up to \$25 per year per member if needed. Now, therefore be it

RESOLVED, That the \$10 per member annual assessment for the Tennessee Medical Association Student Education Fund (originally implemented with the passage of Resolution No. 5-82 and subsequently reaffirmed with the passage of Resolution No. 1-89) be combined with the \$15 per member annual assessment for the Tennessee Medical Association Student Education Fund (originally implemented with the passage of Resolution No. 3-83 and subsequently reaffirmed with the passage of Resolution No. 1-90) to constitute a single per member annual assessment of \$25, applicable only to active members of the Association; and be it further

RESOLVED, That Resolution No. 1-89 be allowed to sunset, and that Resolution No. 1-90 be hereby terminated; and be it further

RESOLVED, That the Tennessee Medical Association Student Education Fund Board be urged to undertake a thorough study and evaluation of the program and bring back to the House of Delegates in 1997 an informational report and strategic plan for its continued operations and finances.

REFERENCE COMMITTEE C—*recommended adoption of Resolution No. 9-96.*

ACTION: ADOPTED

RESOLUTION NO. 10-96

Annual Component Society Report on Adoption of Peer Review Guidebook

H. VICTOR BRAREN, MD, CHAIRMAN
TMA JUDICIAL COUNCIL

Whereas, In April 1991, the Tennessee Medical Association (TMA) House of Delegates amended TMA's Constitution and By-laws to empower the Board of Trustees to create a procedures booklet to govern how component societies conduct peer review of member physicians; and

Whereas, In October 1991, the Board of Trustees issued the peer review booklet which is based in part on suggested procedures outlined by the American Medical Association and distributed it to all TMA component societies for their adoption and use; and

Whereas, Anecdotal reports indicate that not all TMA component societies have adopted the procedures, a reporting mechanism should be put in place so that the House of Delegates can ensure that each component society follows the procedures and gives member physicians due process; and

Whereas, Since component societies are currently required to make an annual report to the House of Delegates, an additional statement on peer review activities should be part of the report, which would enable the Judicial Council to address any questions and offer societies necessary guidance. Now, therefore be it

RESOLVED, That all Tennessee Medical Association (TMA) component societies file with their annual reports to the House of Delegates a statement on the status of their peer review procedures, including whether they have adopted the use of the required TMA Board of Trustees Peer Review Procedures Booklet.

REFERENCE COMMITTEE C—*recommended adoption of Resolution No. 10-96.*

ACTION: ADOPTED

RESOLUTION NO. 11-96

Commission on Office Laboratory Accreditation (COLA)

ROBERT R. CASEY, MD, DELEGATE
ROANE-ANDERSON COUNTY MEDICAL SOCIETY

Whereas, The Commission on Office Laboratory Accreditation (COLA) is the only not-for-profit education and accreditation organization specifically designed to meet the needs of physician-directed laboratories that are practice-based and was founded by the American Academy of Family Physicians, the American Medical Association, the American Society of Internal Medicine, and the College of American Pathologists; and

Whereas, COLA is approved by the Health Care Financing Administration as an educational alternative to federal certification of laboratories under the Clinical Laboratory Information Act of 1988 (CLIA '88). Now, therefore be it

RESOLVED, That the Tennessee Medical Association endorse the accreditation program for laboratories of the Commission on Office Laboratory Accreditation (COLA), and be it further

RESOLVED, That the Tennessee Medical Association publicize information about the Commission on Office Laboratory Accreditation (COLA) and inform physicians of the availability of clinical laboratory accreditation through COLA as a peer review alternative to federal certification under Clinical Laboratory Improvement Act of 1988 (CLIA '88).

REFERENCE COMMITTEE B—*recommended adoption of Resolution No. 11-96 as amended.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 12-96

Human Immunodeficiency Virus (HIV) Testing of All Pregnant Women

JESSE C. WOODALL, MD, CHAIRMAN
COMMITTEE ON MATERIAL & CHILD CARE

Whereas, Human Immunodeficiency Virus (HIV) testing is considered appropriate in high-risk populations and other populations that may be at unknown risk; and

Whereas, There is now a method of treating women who are HIV-positive to significantly reduce transmission of HIV (from 25% to 8%) to *in utero* infants; and

Whereas, HIV infection is increasing at a high rate in heterosexual women in Tennessee and elsewhere in the United States. Now, therefore be it

RESOLVED, That the Tennessee Medical Association urge that the Tennessee General Assembly mandate and fund Human Immunodeficiency Virus (HIV) testing and therapy for all pregnant women.

REFERENCE COMMITTEE B—*recommended adoption of Resolution No. 12-96 as amended.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 13-96

Early Discharge of Mothers and Infants from the Hospital

JESSE C. WOODALL JR., MD, CHAIRMAN
COMMITTEE AND MATERNAL & CHILD CARE

Whereas, Some insurance entities now require discharge from the hospital at intervals that are inappropriate for safe child and mother care and recovery; and

Whereas, Many other states at this time are requiring an extended length of stay possibility for these patients; and

Whereas, This is consistent with good medical care. Now, therefore be it

RESOLVED, That the Tennessee Medical Association recommend to the Tennessee General Assembly, through its regulation of insurance companies, that all postpartum females who deliver newborn infants in this state be allowed an adequate amount of insurance reimbursed time for recovery in the hospital with the time period to be determined by the physicians who provide care for the mother and infant.

REFERENCE COMMITTEE B—*recommended adoption of Resolution No. 13-96 as amended.*

ACTION: ADOPTED AS AMENDED

SUBSTITUTE RESOLUTION NO. 14-96

Affiliation With Nurse Practitioners

EDWARD CAPPARELLI, MD, PRESIDENT
COCKE COUNTY MEDICAL SOCIETY

RESOLVED, That the Tennessee Medical Association reevaluate and revise its guidelines for physicians who supervise nurse practitioners and physician assistants, and that this be done in a timely manner.

REFERENCE COMMITTEE B—*recommended referral of Resolution No. 14-96 to the Board of Trustees.*

ACTION: REFERRED TO THE BOARD OF TRUSTEES

RESOLUTION NO. 15-96

Managed Care Gag Rules

DAVID K. GARRIOTT, MD, EX-OFFICIO DELEGATE

Whereas, By training and public expectation physicians are patient advocates; and

Whereas, Historically, the physician-patient relationship has been one of openness and honesty so as to encourage thorough and complete health care; and

Whereas, Physicians are ethically bound to provide their patients with sufficient information about the patients' health conditions, whether by diagnoses, prognoses, or related issues, so that the patients may make informed decisions about the types of health care services that they need; and

Whereas, This advocacy relates not only to delivery of the best medical care a physician in his/her judgment can deliver but also to the ethical issues which arise in some managed care contracts that contain clauses precluding physicians from providing their patients with all relevant medical treatment information, including coverage or benefits matters; and

Whereas, Increasingly, as health care insurers have sought to restrain treatment costs, they have pressured physicians to persuade their patients to choose less costly treatment plans, sometimes at the expense of quality, and have done so by means of contractual clauses prohibiting physicians from disclosing alternative forms of treatment which are not approved for reimbursement by the insurance carriers. Now, therefore be it

RESOLVED, That the Tennessee Medical Association warn member physicians about unethical or illegal language or requirements in managed care contracts so that physicians will be in a better position to protect their patients' right to fully informed consent and to avoid licensure sanctions by the Tennessee Board of Medical Examiners; and be it further

RESOLVED, That the Tennessee Medical Association (TMA) petition either the Tennessee Board of Medical Examiners (BME) or the Tennessee General Assembly, as necessary, to declare unethical and illegal certain types of gag clauses or gag rules in health insurance contracts which prohibit physicians from fully advising their patients about medical treatment, and so advise TMA members and the media about the BME action, or legislative initiative, as the case may be.

REFERENCE COMMITTEE A—*recommended adoption of Resolution No. 15-96 as amended.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 16-96

Physician's Role in Managed Care

CHARLES R. HANDORF, MD, DELEGATE
MEMPHIS & SHELBY COUNTY MEDICAL SOCIETY

Whereas, In this time of increased competition among physicians, hospitals, insurance companies and other health care deliverers, and with the evolution of the health care delivery systems, physicians must remain advocates for their patients; and

Whereas, Physicians have the greatest understanding of the impact of these competitive and market changes on the health care their patients receive; and

Whereas, Physicians are in the best position to create, manage, and deliver patient care through the new vehicles of health care delivery; and

Whereas, It is incumbent upon physicians to maintain their position as "captain of the ship" in this new age of medicine. Now, therefore be it

RESOLVED, That the Tennessee Medical Association continue its efforts to educate physicians and the public through the Community Awareness Resource and Education (CARE) Program on how to cope with the changing medical environment; and be it further

RESOLVED, That the Tennessee Medical Association continue to encourage physicians to become more involved in management and direction of health care companies since physicians will be the strongest patient advocates; and be it further

RESOLVED, That physicians be given equal opportunities by regulatory agencies to compete in the marketplace not only as providers but as owners and directors of high-quality, patient-oriented health care delivery and reimbursement systems.

REFERENCE COMMITTEE A—*recommended adoption of Resolution No. 16-96 as amended.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 17-96

Utilization Review

CHARLES R. HANDORF, MD, DELEGATE
MEMPHIS & SHELBY COUNTY MEDICAL SOCIETY

Whereas, Utilization Review (UR) is conducted by more and more insurance companies and managed care organizations; and

Whereas, During the UR process, physicians should deal with physician reviewers who are in the same or similar specialty; and

Whereas, When physicians appeal an adverse UR decision, they should be provided with written decisions based on recognized clinical criteria; and

Whereas, Physicians should not be terminated from managed care plans for advocating the best interests of their patients. Now, therefore be it

RESOLVED, That the Tennessee Medical Association pursue passage of legislation to require that at some point during utilization review the physician reviewer be in the same specialty as that of the patient's physician; and be it further

RESOLVED, That the Tennessee Medical Association pursue passage of legislation to require that decisions involving utilization



TMA Past Presidents attending the annual breakfast in their honor.

review appeals be rendered in writing, state the criteria used, and be based on recognized clinical criteria; and be it further

RESOLVED, That the Tennessee Medical Association pursue passage of legislation to prohibit managed care organizations from terminating or otherwise sanctioning the physicians in their networks for advocating in the interests of their patients.

REFERENCE COMMITTEE C—*recommended adoption of Resolution No. 17-96 as amended.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 18-96

Evaluation of Managed Care Programs

CHARLES R. HANDORF, MD, DELEGATE
MEMPHIS & SHELBY COUNTY MEDICAL SOCIETY

Whereas, Physicians are entering into more and more managed care contracts; and

Whereas, Physicians and patients do not receive enough information to assess which plans perform as advertised; and

Whereas, Physicians need to be cautious and informed about managed care because managed care offers both opportunities and areas of concern for their practice; and

Whereas, Physicians have no definitive and independent resource from which to find information on how these managed care programs can affect their practice. Now, therefore be it

RESOLVED, That the Tennessee Medical Association develop a program to provide physicians with a systematic, data-based method for evaluating managed care programs in Tennessee and allow this useful information to be distributed to the public.

REFERENCE COMMITTEE A—*recommended referral of Resolution No. 18-96 to the Board of Trustees.*

ACTION: REFERRED TO THE BOARD OF TRUSTEES

RESOLUTION NO. 19-96

Outstanding Physician of the Year Award

CHARLES T. WOMACK, MD, CHAIRMAN
TMA BOARD OF TRUSTEES

Whereas, The General Practitioner Award originated in 1951 and was modified in 1957 to be named the Outstanding Physician of the Year Award; and

Whereas, Over the years this Association has been privileged to honor many worthy recipients with this award; and

Whereas, Using an election process may discourage qualified candidates from being renominated even though their worthiness is unquestioned; and

Whereas, The Outstanding Physician of the Year Award recognizes lifetime achievement and the Tennessee Medical Association Board of Trustees recognizes achievement within the previous year with its Distinguished Service Award; and

Whereas, More physicians could receive recognition if the Outstanding Physician of the Year Award was broadened to a selection process rather than an election process. Now, therefore be it

RESOLVED, That the Tennessee Medical Association Outstanding Physician of the Year Award be changed to a selection process and be called the "Outstanding Physician Award"; and be it further

RESOLVED, That the same criteria for the Outstanding Physician of the Year Award be used for the Outstanding Physician

Award and that nominations be submitted to the House of Delegates Nominating Committee for selection of up to three recipients annually with not more than one to come from the same grand division; and be it further

RESOLVED, That the Outstanding Physician Award recipients be confirmed and recognized at the Tennessee Medical Association Annual Meeting during the meeting of the House of Delegates.

REFERENCE COMMITTEE C—*recommended adoption of Resolution No. 19-96 as amended.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 20-96

Modified Community Rating Insurance Plans

JOHN J. WARNER, MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

Whereas, Modified community rating plans enacted in many states have resulted in an increase in the percentage of people with health insurance coverage in those states; and

Whereas, The percentage of people with health insurance coverage in Tennessee is declining as budgetary constraints limit TennCare enrollment; and

Whereas, The experience with modified community rating plans has not been universally positive due to variations in their provisions which includes the need for careful consideration. Now, therefore be it

RESOLVED, That the Tennessee Medical Association Board of Trustees, with the advice of the Committee on Legislation and the Committee on Governmental Medical Services and Third Party Payors, study in detail the desirability of community ratings in Tennessee and report its recommendations to the 1997 House of Delegates.

REFERENCE COMMITTEE A—*recommended nonadoption of Resolution No. 20-96.*

ACTION: ADOPTED AS AMENDED

SUBSTITUTE RESOLUTION NO. 21-96

Health Insurance Coverage Reform

JOHN J. WARNER, MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

RESOLVED, That the Tennessee Medical Association take a proactive role in encouraging regulatory agencies and legislators to secure for patients the following critical improvements in their health care coverage: (1) guarantee the renewability and transferability of health care coverage, (2) require reasonable time limits on the waiting period for initiation of health insurance coverage, (3) establish reasonable limitations on out-of-pocket expenses and on time limits for preexisting conditions, and (4) report progress to the House of Delegates at the 1997 Annual Meeting; and be it further

RESOLVED, That the Tennessee Medical Association take an active role with physicians by promoting patient education about health insurance and health care legislation to better serve their needs.

REFERENCE COMMITTEE A—*offered Substitute Resolution No. 21-96 to replace original Resolutions Nos. 21-96 through 24-96; recommended adoption of Substitute Resolution No. 21-96.*

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 22-96

Increased Portability of Health Insurance

JOHN J. WARNER, MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

RESOLUTION NO. 23-96

Limiting Out-of-Pocket Expenses for Pre-Existing Conditions in Health Insurance

JOHN J. WARNER, MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

RESOLUTION NO. 24-96

Limitation of Preexisting Conditions Exclusions in Health Insurance

JOHN J. WARNER, MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

REFERENCE COMMITTEE A—*offered Substitute Resolution No. 21-96 to replace original Resolutions Nos. 21-96 through 24-96; recommended adoption of Substitute Resolution No. 21-96.*

ACTION: (Was replaced with Substitute Resolution No. 21-96 which was adopted as amended.)

RESOLUTION NO. 25-96

Physician-Patient Advocacy in the TennCare Partners Program

THOMAS K. BALLARD, MD, EX-OFFICIO DELEGATE
CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE

Whereas, The Tennessee Department of Finance and Administration (F & A) has applied for and received from the Health Care Financing Administration (HCFA) a waiver for its proposed TennCare Partners Program (the Program), which will soon replace the state's current system of providing Medicaid reimbursement for all mental health and substance abuse services; and

Whereas, During and after the time in September 1995, when the administration applied for this waiver, it did not seek (and has not since sought) any input from, or disclosed any of its application documents to, the Tennessee Medical Association (TMA) or any other organized group of physicians, a pattern that matches how TennCare was originally created; and

Whereas, From the documents that the TMA has just received from HCFA and F & A, it appears that the Program will start soon after May 1, 1996, have a budget of \$350 million, of which \$100 million will come from the TennCare budget, and use five Behavioral Health Organizations (BHOs) to provide all-long term and episodic mental health and substance abuse services to the 1.2 million TennCare recipients; and

Whereas, The administration has signed agreements with all five BHOs and will provide each company with a capitation fee per member per month of approximately \$22, \$7.53 of which will be carved out of the monthly fee now paid to the TennCare managed care organizations; and

Whereas, The TMA is concerned that the manner in which the administration plans to administer the Program will mean that once

a physician attempts to provide even the most routine types of treatment for depression or other mental health needs, the patient will be transferred immediately to the auspices of a BHO with a completely new set of bureaucratic and utilization rules, none of which have yet been disclosed to the TMA; and

Whereas, Since each BHO must provide statewide coverage to enrollees and the state has already approved the BHO provider networks as part of the waiver process, it appears that each BHO must sign up numerous providers, particularly in rural areas, to meet their regional care requirement of being within 30 to 60 miles of enrollees' homes; and

Whereas, Physicians statewide have lost faith in state government because TennCare was created in secret, implemented in great haste with no foresight or medical input, and every systemic change since the January 1, 1994 start date has followed this pattern with the TennCare Partners Program being the latest example; and

Whereas, Given the tight budgetary constraints already placed on the TennCare system, other funding sources, instead of the constant method of shifting all risk of underfunding to physicians, are needed to ensure that the proposed TennCare Partners Program is adequately capitalized. Now, therefore be it

RESOLVED, That the Tennessee Medical Association (TMA) urgently call upon the Sundquist Administration to fully disclose to the TMA all draft rules, program policies, and the behavioral health organization contract for the TennCare Partners Program; and be it further

RESOLVED, That the Tennessee Medical Association (TMA), in its urgent petition to the Sundquist Administration for substantive and direct physician input into the design of the TennCare Partners Program, request that the Program's start date be put off for several months so that the TMA physician and patient advocacy effort will have a positive effect on the final architecture of the Program.

REFERENCE COMMITTEE C—*recommended adoption of Resolution No. 25-96.*

ACTION: **ADOPTED**

RESOLUTION NO. 26-96

Freedom of Local Government Act

PETER W. CARTER, MD, DELEGATE
KNOXVILLE ACADEMY OF MEDICINE

Whereas, The Tennessee Medical Association (TMA) House of Delegates has adopted a resolution recommending a ban on the sale and use of tobacco products in Tennessee hospitals; and

Whereas, The TMA House of Delegates has adopted a resolution continuing a no smoking policy for meetings of the House of Delegates and scientific sessions and has supported the efforts of the American Medical Association to achieve a ban of all advertising and promotion of tobacco products; and

Whereas, The TMA House of Delegates called for adoption of a smoke free policy for all indoor public places in Resolution No. 10-89; and

Whereas, The 1994 Tobacco Youth Access Bill preemption provision does not allow local governments to pass any tobacco control ordinances; and

Whereas, It is imperative that the TMA take a position to encourage the General Assembly in passage of public health measures. Now, therefore be it

RESOLVED, That the Tennessee Medical Association encourage the Tennessee General Assembly to enable local governments to establish their own tobacco control ordinances.

REFERENCE COMMITTEE A—*recommended adoption of Resolution No. 26-96 as amended.*

ACTION: **ADOPTED AS AMENDED**

RESOLUTION NO. 27-96

Medicaid Class Action Lawsuit Against the Tobacco Industry

ROBERT W. HERRING JR., MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

Whereas, Several states have filed a class action lawsuit in federal court against all tobacco companies on behalf of all smokers; and

Whereas, These state plaintiffs seek to recover prior Medicaid budgetary expenditures made in the treatment of Medicaid recipients' tobacco related illnesses; and

Whereas, Like all other states, Tennessee has faced similar budgetary expenditures in both its prior Medicaid program and the current TennCare program; and

Whereas, Tennessee should immediately join this class action lawsuit in order to recover its share of such expenses and to provide additional prospective funding for TennCare. Now, therefore be it

RESOLVED, That the Tennessee Medical Association urge both the Administration and the Tennessee Attorney General to file the necessary documents to join other states in their ongoing federal class action lawsuit against the tobacco industry to recover the costs of treating Medicaid recipients for tobacco use related disease.

REFERENCE COMMITTEE A—recommended adoption of Resolution No. 27-96.

ACTION: ADOPTED AS AMENDED

RESOLUTION NO. 28-96

Problems of the Rural Physician

EDWARD W. CAPPARELLI, MD, DELEGATE
COCKE COUNTY MEDICAL SOCIETY

Whereas, The Tennessee Medical Association is charged with caring for all of its member physicians; and

Whereas, Ten percent of Tennessee's physicians live in rural counties; and

Whereas, A medical support structure for consultation and continuing medical education is often lacking in rural areas; and

Whereas, TennCare has struck the rural physician and hospital inordinately heavily due to their greater percentage of TennCare patients. Now, therefore be it

RESOLVED, That the Tennessee Medical Association expand the scope of the Committee on Rural and Community Health to deal with the problems of the rural physician.

REFERENCE COMMITTEE B—recommended adoption of Resolution No. 28-96 as amended.

ACTION: ADOPTED AS AMENDED

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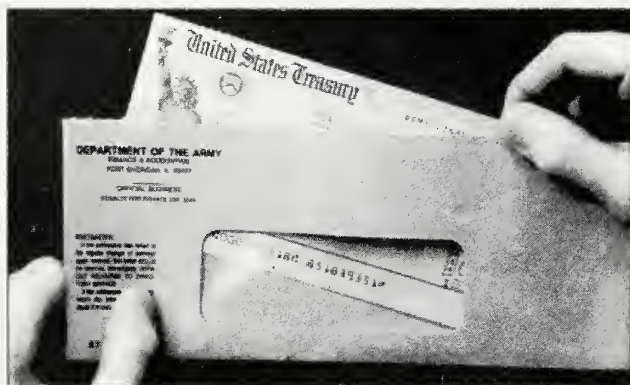
eral vascular surgery, colon-rectal surgery, orthopedic surgery, neurosurgery, urology, anesthesiology, diagnostic radiology, family practice, emergency medicine or internal medicine.

Once you complete your residency you will have opportunities to continue your education and attend conferences. Your commitment in the Army Reserve is generally one weekend a month and two weeks a year or 12 days annually. You can also choose a non-active assignment and receive one-half of the authorized stipend.

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Report of the President

ROBERT E. BOWERS, MD



Bowers

Undoubtedly, the first thing that comes to mind when I review the year I have just spent as president of the Tennessee Medical Association is the tremendous success we had with our efforts toward educating physicians and the public throughout Tennessee on the issues of domestic violence. With the help of our most capable and competent TMA Alliance we distributed literature to physician offices, brought in speakers such as Denise Brown, and manned hot-lines across the

state offering help to families in distress. Hopefully, these efforts will have a significant, long-term impact in decreasing the incidence of domestic violence across our state. This was one of our top priority projects for the year, and I feel the program was very successful.

We also worked diligently with experts in developing a strategic plan for the TMA. We felt that the strategic plan was necessary because of the rapidly changing climate of health care and the need to keep abreast of these changes. We came away with clear-cut ideas and definable, measurable goals for the future of the TMA, a new vision, and refreshed enthusiasm for recruiting new members into this most important organization.

Our TMA Alliance, led by its president, Mrs. Lyn Overholt, has proven an invaluable asset this year. This is a component association that we could and should utilize to its fullest. The TMA Alliance membership is a group of intelligent, generous, innovative individuals—traits that we highly value in both the TMA and in our communities. They deserve special thanks and appreciation for the hard work they do on behalf of the TMA year after year.

This year we were able to implement a new computer and telephone system for the TMA that makes available up-to-date technology and better member services. We are now on-line with MEDWIRE and believe that this will prove to be a significant tool in a number of areas, from faster information retrieval to practice management techniques to personal development, and even on-line learning. We look forward to more information about that service at the Annual Meeting.

But the topic foremost in all our minds is that of managed care. I have spoken and written a great deal about managed care this year, and there is still more to be learned, more changes still looming ahead. My fundamental belief is essentially the one I spoke of in my first President's Page, that of taking a hands-on approach and making strategic choices that will enable us to adapt in a positive way. A year later, I am convinced of the soundness of this approach. We must continue to grasp the changes and their significance to us, to our practices, and to the care of our patients. The quality of care that we give to our patients is still the most important issue. We must never forget that we are still the patient's most ardent advocate. This is what we trained for, and that is what we do best.

I want to encourage each of you to take part in the sharing of information with your colleagues, especially those who have not yet joined the TMA. I reiterate that the TMA is the basic tool of physician and patient advocacy in the political process. We need to support the TMA in every feasible way, including recruitment of new members.

I cannot end this year without expressing a word of deep gratitude to the executive officers of the TMA and their support staff who have been untiringly helpful; specifically, Don Alexander as chief executive officer, for his reorganization and the dynamic input he has had at the TMA this year. Thanks also to Jean Wishnick, managing editor of the *TMA Journal* who was always supportive and helpful, and who made my job much easier. Special thanks to Dr. Charles Womack, chairman of the Board of Trustees, and to the Board itself for its support and dedication to "getting the job done."

Finally, as we look to the future of health care, our cherished profession, we see the inevitable changes, some of which many of us may find unpalatable, but inevitable all the same. My conclusion is really very simple—stay true to your duty, and be reminded of Goethe's remarks on duty, "What, then, is your duty? What the day demands." In my view, our day demands that we continue to do what we have always done: Give to our profession and our patients our very best, and perhaps at the end of *our* day to be able to say, "Well done."

Thank you for allowing me this most rewarding and challenging year. I hope I have in some small measure lived up to your expectations.

Report of the Board of Trustees

CHARLES T. WOMACK, MD, CHAIRMAN

*What lies behind us and what lies before us are
tiny matters compared to what lies within us.*

—Oliver Wendell Holmes



Womack

The health care environment is undergoing fundamental and revolutionary changes. Perhaps the key change can be found in the development of better communications. We have called this year at the TMA the "communications year." In order to be ready for the year 2000, a primary focus has been in devoting resources to advance the organization in the areas of cyberspace and the electronic age. To that end, we have a World Wide Web presence on the Internet, where our members can easily access timely information.

When things change and new information comes into existence, it's no longer possible to solve today's problems with yesterday's solutions. In order to better communicate with one another we have developed a Local Area Network at the TMA headquarters which will allow us to position ourselves for better member services. This was directed by the House of Delegates in 1994 and has now come to fruition under the Board of Trustees oversight.

A new paradigm for health care management is emerging. The opportunities call for a fresh approach, a new way of managing care. What's needed is a new way of communicating and viewing information in order to ensure a real world advantage in the health care field. Fortunately, with increased pressures comes the opportunity to excel. Any organization dedicated to the issue of survival will need

to develop efficient communication of facts and information. Information is the basis of good decision-making. Because of the TMA's proactive approach concerning communications, our Association will continue to evolve and we will endeavor to develop and provide our members with the most effective tools possible for streamlining and redirecting our organization to thrive in this new environment.

On a more intimate level, the TMA Board is pleased to have the president of the TMA Alliance as an official advisor to the Board. Her input, and that of our three regional vice-presidents, is invaluable as we attempt to reach agreement by consensus.

A more descriptive report of the activities and highlights of this past year appear as an addendum to this report. The most important of these activities was the adoption of the strategic plan. Each member is encouraged to read this plan (to be published in a future issue of the *Journal*; you may obtain a copy from TMA Headquarters).

Also, you will find the summary minutes of our quarterly Board of Trustees meetings in the *Journal of the TMA*. This serves not only as a historical record of our actions, it gives each member of the Association direct access to the policies and activities of the Board.

To operate effectively in today's health care environment, physicians must assess both the threats and the opportunities that confront them. All in all the synergy of the different Board members has helped formulate a long range plan to help the TMA and its members to survive. If we can take care of our patients and of ourselves into the next century, then we will have been successful.

Addendum A

Resolution No. 6-95

Subject: Physician Malpractice Protection as "State Employees" When Treating TennCare Patients.

Action: This resolution was adopted by unanimous consent April 9, 1995, and called upon the TMA Committee on Legislation to pursue passage of tort reform for TennCare physicians. Although the TMA has had such a bill on file with the 99th General Assembly both in 1995 and 1996, the committee recognizes that prospects of passage seem bleak, meaning that TMA must push other bills of interest to the membership.

Resolution No. 7-95

Subject: TMA Annual Dues.

Action: The dues bills for membership in the TMA for 1996-97 included the increase that was approved by the House of Delegates. Annual dues to the TMA are \$395.

Resolution No. 8-95

Subject: Contract Review.

Action: This resolution, recommended for nonadoption by Reference Committee C, was referred to the TMA Board of Trustees for decision. The Board has considered the resolution carefully, and has incorporated the concept of a TMA initiated or sponsored contract review service as part of the Long Range Plan. At this time, TMA's Legal Department is examining the system used by the Texas Medical Association which has named certain attorneys who provide contract review services at the nominal rate of \$100 per contract reviewed.

Resolution No. 9-95

Subject: Home Health Care Patient Orders.

Action: This resolution was adopted by unanimous consent April 9, 1995. It called upon TMA to urge member physicians not to sign orders for home health care for patients who are not under their care. The resolution was published in the June edition of the *Journal of the TMA*. The resolution, as required, was sent under signature of the chairman of the Interprofessional Liaison Committee to the Tennessee Association for Home Care as a request that agencies refrain from making such inappropriate physician signature requests.

Resolution No. 11-95

Subject: Team Physician Support for Local High Schools.

Action: All Tennessee high school principals and athletic directors across the state were contacted by letter as part of a campaign by the TMA Sports Medicine Committee to identify local sports programs that lacked proper medical support. Simultaneously, the presidents and secretaries of all TMA component medical societies were contacted with the names, addresses, and telephone numbers of area high schools and urged to make contact. In this initial effort, TMA identified six local schools that needed additional medical assistance with their sports programs and successfully matched each with leaders of area medical societies. The committee plans a follow-up mailing by the end of the 1996 school year.

Resolution No. 12-95

Subject: Registration Fees Charged to Members for Attendance at Annual Meeting.

Action: The Board of Trustees along with its Annual Meeting Committee reviewed in-depth the various factors involved in charging a nominal fee for members who attend the Annual Meeting. After thorough review and discussion the Board of Trustees reaffirmed its policy that the nominal fee for this event needed to remain in place for the 1996 Annual Meeting. The Board also was of the opinion that the incentives for early registration and the ability to buy packages for special events was a cost-saving measure for physicians.

Resolution No. 13-95

Subject: Tennessee Medical Association Membership.

Action: The dissemination of the TMA nondiscrimination policies was outlined in the June 1995 issue of the *Journal of the TMA*. In addition, each delegate to the House of Delegates in 1995 received a copy of the actions of this policy as did every component society president and secretary through a special mailing.

Resolution No. 14-95

Subject: Membership Recognition Awards Program.

Action: The purpose of this resolution is to recognize physicians who have been members of TMA for five, 10, and 25 years in addition to the current policy of recognizing 50-year members. Such members will be awarded with pins, badges, and/or plaques, depending upon their longevity of membership. The 25-year members will be recognized at the House of Delegates meeting in April, 1996.

Resolution No. 15-95

Subject: Ballard Motion.

Action: The Ballard Motion is now an official motion accepted as part of the parliamentary procedure of the TMA House of Delegates.

Report of the Judicial Council

H. VICTOR BRAREN, MD, CHAIRMAN

The Judicial Council of the Tennessee Medical Association met in full session once following its organizational meeting during TMA's April 1995 House of Delegates meeting. In August 1995, we reviewed a physician's appeal of an adverse peer review decision by the Chattanooga-Hamilton County Medical Society (CHCMS). The physician asked the Council to reverse or modify the CHCMS Judicial Council's decision to censure him. The Council affirmed the CHCMS' first finding that the physician violated the CHCMS Bylaws by failing to cooperate with the Grievance Committee in the disposition of a patient's complaint. The Council reversed the re-

mainder of the decision because the patient did not appear at the evidentiary hearing, and there was no record of a detailed interview to examine the allegation's merits. The Council appreciated the CHCMS efforts with that difficult case. No other medical societies reported any other adverse decisions.

The Judicial Council recommended, and the TMA Board of Trustees approved, the inclusion of the American Medical Association's recommended model procedures for the review of fee complaints in TMA's Peer Review Procedures Guidebook. As drafted, component medical societies may and should entertain complaints about physicians' fees, but without engaging in price-fixing in the process. Medical societies, for example, cannot use fee review decisions to establish fee structures for the medical community. The TMA Board agreed that complaints about physicians' fees should be considered as TMA's duty for professional self-regulation. Medical societies should respond to fee complaints regardless of the willingness of the physician to become involved in the process (assuming the physician is a member of the society). The AMA advised the TMA Board that fee reviews may be pursued without fear of antitrust liability as long as the guidelines outlined in the Guidebook are observed.

I consider this a successful year for the Council. As chairman, I wish to thank all of the members of the Judicial Council for their willingness to serve TMA in this important capacity, and those TMA members who assist in local peer review matters.

Report of the Secretary-Treasurer

MICHAEL A. MCADOO, MD



McAdoo

The annual audit for the fiscal (and calendar) year ending December 31, 1995 has been completed and is available for review. The customary examination of the Association's records and accounts was conducted by the firm of Bellenfant and Miles, P.C., certified public accountants, appointed by the Board of Trustees.

The accompanying financial statements have been extracted from the complete audit. They show the revenue and expenditures during 1995 as well as the

assets, liabilities, and fund balance at the end of the year. A balanced budget had been projected for 1995 with revenues and expenditures projected at \$2,421,325. The actual budgeted revenue was \$2,438,776 and budgeted expenses were \$2,398,422, resulting in \$40,354 excess revenue over budgeted expenses.

There were still considerable expenses borne in 1995 by the Association related to TennCare activities. Those activities focused primarily on the continued litigation. In addition, \$50,000 from the CARE program and \$100,000 from TMA Physician Services, Inc. were used to offset litigation and educational expenses.

The House of Delegates in April 1995 approved an additional \$40 of dues of which \$25 went to the continuing operations of the Association. As outlined to the House of Delegates, much of that \$25 would be directed to the installation and implementation of a new information system at the headquarters office. You will note in

1996, \$72,000 has been budgeted for the lease of this information system. Other TMA organizations and subsidiaries that directly benefit from this system are helping to fund the project by paying a monthly user fee.

Over the past several years, the reserves of the Association have continued to decline primarily because of TennCare. In 1996 the Board of Trustees has approved 4% of budget to be set aside toward reserves. Sound Association fiscal management suggests that a minimum of six months annual budget should be held in reserve. TMA is a long way away from that target, however we now can redirect our focus away from TennCare to the other business of the Association from a monetary standpoint.

I appreciate the assistance of Dr. Chris Fleming and Dr. Ron Overfield on the Finance Committee, as well as the cooperation of Mr. Don Alexander, chief executive officer, and the Board of Trustees during 1995.

STATEMENT OF REVENUE, EXPENSES, AND CHANGES IN FUND BALANCE

	Year Ended December 31	
	1995	1994
Revenue		
Membership Dues	\$1,757,895	\$1,774,769
Annual Meeting	114,350	54,585
Journal	59,549	58,047
Investment Income	69,612	73,388
CARE Program		73,902
TMA Physician Services-Dividends	175,000	75,000
AMA Collection Fees	33,877	33,556
Legal Fund Assessment		489,536
Specialty Society Administration	27,716	40,507
Rental Income	130,977	125,009
CME Programs	20,230	18,915
Other	49,570	3,989
Total Revenue	<u>\$2,438,776</u>	<u>\$2,821,203</u>
Expenses		
General Administrative	\$971,775	\$982,637
Administrative Support & Services	58,496	35,117
Travel-Staff	47,953	50,988
Officers and Members	119,823	102,922
Impaired Physician Program	74,175	74,899
Committee Expenses	20,586	15,890
Legislative Committee	89,340	69,571
Continuing Medical Education	10,977	10,604
Annual Meeting	113,653	62,729
Taxes	87,537	83,761
Headquarters Expense	84,445	77,129
Journal	124,432	121,491
Student Education Fund	123,625	124,205
Specialty Society Administration	46,345	52,030
Other Organizations	20,032	20,520
CARE Program	158,590	256,280
Legal Fund	114,265	598,443
Other	42,486	4,472
Depreciation	124,798	126,113
Total Expenses	<u>\$2,433,333</u>	<u>\$2,869,801</u>
Excess of Revenue Over Expenses	5,443	(48,598)
Fund Balance		
Beginning of the Year	2,873,077	2,921,675
End of the Year	<u>\$2,878,520</u>	<u>\$2,873,077</u>

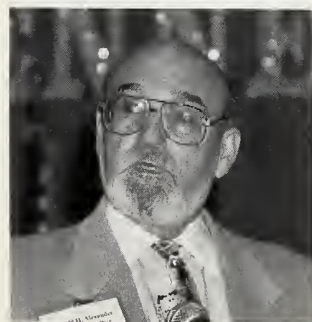
BALANCE SHEET

Year Ended December 31
1995 1994

Current Assets		
Cash and Cash Investments		
Operating Cash	\$ 934,689	\$ 804,042
Reserve Cash	<u>500,000</u>	<u>500,000</u>
Total Cash/Investments	1,434,689	1,304,042
Investment in TMA Physician Services, Inc.	1,000	1,000
Other	<u>1,633</u>	
Total Current Assets	<u>1,437,322</u>	<u>1,305,042</u>
Land, Building & Improvements, Equipment & Autos		
Land	876,995	876,995
Building	1,609,326	1,609,326
Tenant Improvements	120,965	120,965
Office Equipment	287,881	263,161
Automobile	<u>18,571</u>	<u>15,999</u>
	2,913,738	2,886,446
Less Accumulated Depreciation	<u>(608,772)</u>	<u>(491,973)</u>
Land, Building & Improvements, Equipment & Autos-Net	<u>2,304,966</u>	<u>2,394,473</u>
Information Systems Project	<u>200,877</u>	
Total Assets	<u>\$3,943,165</u>	<u>\$3,699,515</u>
Current Liabilities		
Accounts Payable & Accrued Expenses	\$ 12,626	\$ 17,548
Dues Collection Escrow	842,142	743,079
Unearned Annual Meeting Income	7,000	9,215
Note Payable-Third National Bank		54,596
SunTrust Capital Lease	<u>44,086</u>	
Total Current Liabilities	905,854	824,438
SunTrust Capital Lease	156,791	
Tenant Deposits	<u>2,000</u>	<u>2,000</u>
Total Liabilities	1,064,645	826,438
Fund Balance	<u>2,878,520</u>	<u>2,873,077</u>
Total Liabilities and Fund Balance	<u>\$3,943,165</u>	<u>\$3,699,515</u>

Report of the Chief Executive Officer

DONALD H. ALEXANDER



Alexander

As I begin my first report to the House of Delegates I must thank all of those who have given me the chance to lead the Tennessee Medical Association as its chief executive officer. It is indeed an honor and privilege to be associated with, and a partner with, those in this respected profession. Your staff is dedicated to carrying out those activities that you have chosen as your plan for the future. We serve at your direction and plea-

sure and look forward to meeting the challenges with you as we approach the next century.

Over the years in my report, I will use this opportunity to express my thoughts and ideas on the status, progress, and future of the Association and the medical profession in Tennessee. Most of the activities, policies, and programs are described in detail in other officer and committee reports.

In 1995 the TMA, through retirement, lost two of its long-time dedicated staff members: Mr. L. Hadley Williams, and Mr. William (Bill) Wallace. Combined they had almost 60 years of service with the TMA. Replacing two individuals with such knowledge and experience has been difficult.

With a goal to better manage the organization, I have chosen three individuals to lead key departments, and have named Mr. Marc Overlock, Mr. John Grant, and Mr. Russ Miller as senior vice-presidents. Through our reorganization we have identified those areas of greatest need and have focused our attention since last April to make our operations more efficient and responsive to the membership's needs.

In this handbook is a copy of the TMA strategic plan that has been adopted by the Board of Trustees (to be published in a future issue of the *Journal*). Your staff played a vital role in the development of this plan and is a partner in its implementation. With the environment of medicine changing, likewise the organization of the TMA must change with it to meet the most pressing needs of its members.

Some of the administrative and operational changes over the next few years will be invisible to the membership while others will receive high-profile attention. One of the most important things we have undertaken has been the implementation of a new information system replacing an outdated, stand alone PC environment. This system will take us into the 21st century and once fully integrated and on-line will be able to serve the membership in ways we have never been able to before. Some of you may have experienced some minor delays while our system is being installed and staff is being trained. We appreciate your patience if there has been any inconvenience in meeting your requests for information.

I was asked recently by someone from outside the profession what was the greatest challenge facing medicine today. To give an answer I thought he might understand, I began to list things such as Medicare reform, TennCare and its continuing effect on patients, managed care when it is not done right, and a host of other issues. After relating those things I changed my mind after giving the question real thought and noted the greatest challenge to physicians today as it has been for many years is that of *unity*. Without a doubt at times, physicians and physician organizations tend to be their own worst enemy. Unity cannot be legislated, it can't be dictated, it can't be bought. Unity must come from within the individuals who desire to see their profession preserved. As long as medicine allows itself to pit private practitioner against employed practitioner, generalists against specialists, fee for service against capitation, or rural practitioner against urbanite, many would say we deserve what we get.

While we may face extreme difficult challenges, we also have the intelligence and dedication to resist the continued erosion of the profession. I firmly believe that physicians who put their energy and time into solving their problems will eventually make things better for themselves. If we tend to dwell on being part of the problem, then we may well see the profession decline.

I know your Board of Trustees, your staff, and the leaders of your component societies, want to be part of the solutions. What they need is the individual members support, cooperation and involvement in accomplishing solution-based goals.

The lifeblood of any association is its members. I will continue to give you a snapshot of our membership in this annual report as was done by my predecessor. You will note the five-year history of our membership toward the end of this report and see that we are relatively stable as things relate to total membership. However, in

TMA MEMBERSHIP REPORT As of December 31, 1995

	1995	1994	1993	1992	1991
Dues Paying Active Members	5,085	5,121	5,078	5,140	5,116
Dues Paying Resident Members	85	77	71	78	84
Dues Exempt Members	1,586	1,400	1,393	1,322	1,163
Veteran Members	(636)	(599)	(506)	(487)	(544)
Military, Disabled & Retired	(400)	(372)	(446)	(426)	(389)
Student Members	(550)	(429)	(441)	(409)	(230)
TOTAL	6,756	6,598	6,542	6,540	6,363
Deaths	33	62	49	57	42

AMA Members from Tennessee:	
TMA Members	4,806
TMA Direct Members	220
Total AMA State Members	5,026
Non-AMA State Members	1,671
STATE TOTAL	6,697

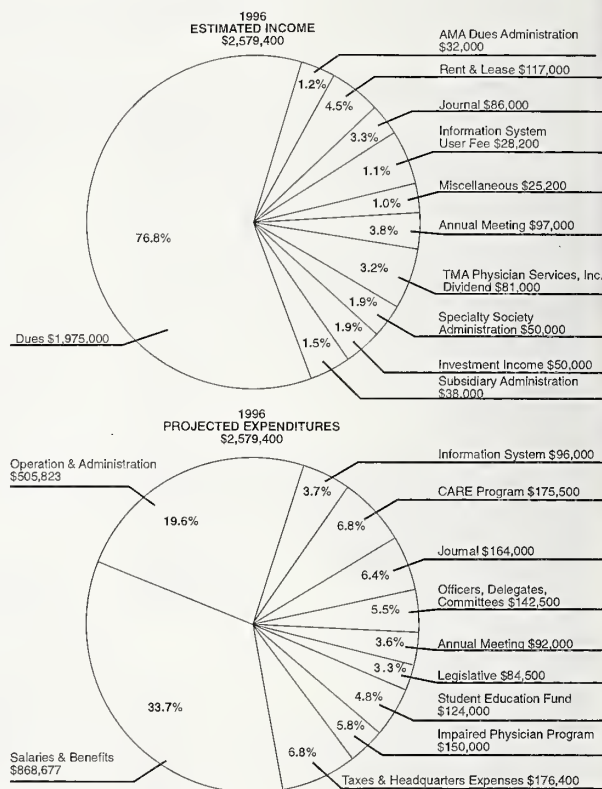
75% of TMA members are AMA members

this day and time stable is not acceptable. We continue to fail in getting younger physicians to join the Association and their peers.

Lastly, the accompanying graphic gives a quick review of the projected income and expenditures for 1996 as developed by the Finance Committee and approved by the Board of Trustees. This represents the largest budget ever for the TMA. Without our diverse revenue sources, in particular the dividend from TMA Physician Services, Inc., dues would have to continue to escalate to meet our financial demands. With the continued watchful eye of the Finance Committee, the TMA will remain a stable and growing organization and will meet the needs of its members.

Again, the Association's staff values the trust you place in us to represent the profession and carry out the policies and work plan you have chosen. □

1996 PROJECTED INCOME AND EXPENDITURES



MOVING? Send Us Your Address

Please notify us six weeks in advance.

Old Address

Name _____
 Address _____
 City/State/Zip _____

New Address

Address _____
 City/State/Zip _____
 Effective Date of New Address _____

Send to: TMA, PO Box 120909, Nashville, TN 37212-0909

Tennessee's Outstanding Physician of the Year

The TMA House of Delegates elected F. Houston Lowry, MD, of Madisonville, as the 1996 Outstanding Physician of the Year at the 161st TMA Annual Meeting in Knoxville.



Lowry

Dr. F. Houston Lowry Jr., a certified diplomate of the American Board of Family Practice, has maintained a private family medicine practice in Madisonville, Tennessee, since 1955. He was nominated to receive this honor by his fellow members in the Monroe County Medical Society for his lifelong dedication to medicine, his patients, and the citizens of Monroe County.

A graduate of the University of Tennessee College of Medicine in 1953, Dr. Lowry re-

ceived his undergraduate degree from Maryville College in Maryville.

Following his graduation from medical school, he entered his internship in North Carolina. During that time, he contracted polio. Despite his handicap, Dr. Lowry finished his internship and returned

to Madisonville to open a medical practice in the town where he had grown up.

Dr. Lowry practiced in Madisonville until 1977 and left briefly to serve on the medical staff of the Veterans Administration Hospital in Nashville through 1979. He returned to Madisonville where he continues to operate his solo practice today.

In addition to his medical service to Monroe County and patients from surrounding areas, he has served in countless civic leadership roles in his community, statewide, and within the Tennessee Medical Association. He is a director of the Bank of Madisonville, serves on the Board of the Great Smoky Mountain Gatlinburg Highland Games, is deeply involved in scouting leadership activities, has served as team doctor for the local high school for more than 30 years, has been a member of the county board of health and county court, and was chief of staff of the Sweetwater Hospital from 1982-1984.

In the TMA, Dr. Lowry has directed the Community and Rural Health Programs across the state for 25 years, has served on many different committees, and has served as a delegate to the TMA from Monroe County for many years. For his contributions to the TMA and to medicine in his community, Dr. Lowry received the TMA Distinguished Service Award in 1993.

Distinguished Service Awards

The Distinguished Service Award, established in 1964, is presented annually by the TMA Board of Trustees to member physicians in recognition of outstanding service or contribution to the advancement of medical science, the TMA, or the public welfare, whether civic or scientific in nature. At TMA's 161st Annual Meeting in Knoxville, TMA Board Chairman Charles T. Womack, MD, presented two worthy recipients with this prestigious award.



Freeman

Jerre M. Freeman, MD, a Memphis ophthalmologist, was nominated for this year's award for his continuing work with the World Cataract Lens Project, an international nonprofit health organization which focuses on cataract blindness in the developing countries around the world.

In 1978, Dr. Freeman created a worldwide organization to restore the sight to those patients blinded by cataracts through teaching, service, and research. Today, he still serves as chairman of the Project.

Through his continued work with the Mission Cataract USA program, Dr. Freeman helps to provide free screenings and cataract surgeries for patients who have no insurance or means to pay.

Last year, Dr. Freeman hosted three Chinese ophthalmologists for a four-month study period to learn new techniques in cataract

surgery and intraocular lens implantation. He also led a 23-member team of medical personnel to Mexico to provide free screenings and eye surgery for disadvantaged natives in the region.

Not only did Dr. Freeman give of his time and talents, he also funded the participation of three other team members. In total, more than 500 patients were screened and 100-plus surgeries were performed during their mission to Mexico.

He received his medical degree from the University of Tennessee in 1963 and completed his ophthalmology residency in 1967. He completed his Heed Fellowship at Harvard Medical School in 1968, and in 1975 received specialized intraocular lens implantation training from Dr. C.D. Binkhorst in the Netherlands.

Prior to entering medical school, Dr. Freeman received his bachelor's degree in mechanical engineering while on a naval scholarship at Auburn University. Upon graduation, he was a US Navy pilot from 1956 to 1959.

In private practice since 1968, Dr. Freeman is founder and chairman of the Memphis Eye and Cataract Associates (MECA), an outpatient ophthalmic surgical center, the first of its kind in Tennessee. He specializes in cataract surgery, microsurgery of the anterior segment of the eye, intraocular lens implants, and refractive surgery.



Mehta

Jay B. Mehta, MD, FCCP, a pulmonologist in Johnson City, received this year's award for his continuing work to eradicate all strains of tuberculosis (TB) not only in the tri-cities area but across the state and nationally.

The members of the Washington-Unicoi-Johnson County Medical Association whole-heartedly believe that the incidence of TB has decreased among the population in East Tennessee due to Dr. Mehta's efforts for the past 20 years. More specifically, Dr. Mehta's work with the TB Control Program since 1994 has re-

sulted in a total eradication of drug resistant TB in East Tennessee. In 1991, 1992, and 1993, the percentage of drug-resistant TB was about 7%. In 1994, there were no recorded cases in the region.

Dr. Mehta came to the Johnson City area in the late 1970s, and it was then that he began a career fighting, studying, and teaching about TB. Since that time, he has chaired and worked on countless commit-

tees and task forces dealing with TB and other public health issues.

Currently Professor of Medicine in the Department of Internal Medicine at Quillen College of Medicine at East Tennessee State University, he is also the Director of Pulmonary Teaching Services at the Johnson City Medical Center Hospital and is a member of a private pulmonary practice group. His physician colleagues credit him for bridging the "town and gown" gap within the medical community that sometimes exists between physicians in private practice and teaching physicians.

Due to Dr. Mehta's efforts, the Tennessee Department of Health and the TB Control Program received an educational grant for approximately \$15,000 for a first-of-its-kind statewide symposium on TB that took place this March, with more than 350 physicians and nurses attending. Also, he continually helps to secure national speakers and noted visiting professors to further elevate the education of the citizens and physicians of the region.

Born in India, Dr. Mehta received his medical degree in 1969 from the Government Medical College in Baroda, India. He completed his internal medicine residency at the Veterans Administration Hospital in Northport, N.Y. in 1974, and his fellowship in pulmonary medicine in 1976. In 1977, he completed a tuberculosis and chest fellowship in Denver. He is board certified in Internal Medicine and Pulmonary Medicine.

Community Service Awards

Each year since 1976, the Tennessee Medical Association has been privileged to present its Community Service Award to citizens who have made contributions to their community and state in the field of health care. At the TMA's 161st Annual Meeting in Knoxville, TMA Board of Trustees Chairman Charles T. Womack, MD, presented the awards to this year's recipients for their efforts to promote better general health and well-being in their respective communities.



Cates

Mrs. Bena Cates was nominated for this year's award by the Memphis & Shelby County Medical Society for creating the Good Samaritan Awards, her dedication to the Church Health Center (CHC), and for her general volunteer contributions to her community.

She currently serves as the assistant to the director of the CHC and directs special projects and fundraising events. Among the special events which she established is the Good Samaritan Awards Program, created to recognize out-

standing contributions to the local health care community that might otherwise go unnoticed. The CHC is a health care ministry which provides needed health care services to the indigent population of Memphis with the volunteer help of the medical community. The CHC received the 1988 TMA Community Service Award.

In addition to her work with the CHC's Good Samaritan Awards, she has been a driving force behind many organizations that help to fund special scholarships for the needy in Memphis. She helped create the Metropolitan Interfaith Association's (MIFA) Development Board and founded the Brooks Anderson Memorial Scholarship for the Memphis Academy of Art.

The Mid-South Minority Business Council also has benefited from Mrs. Cates' volunteer spirit. She helped originate the Council's Partners Program, which brings minority and majority businesses together. For her efforts to create the program, she recently received the Council's Distinguished Volunteer Award.

Mrs. Evelyn Overholt was nominated for this year's award by the members of the Knoxville Academy of Medicine for her direction of a pilot project to create the East Tennessee Foundation Youth Leadership Program and the creation of the High School Parenting/Preschool Learning Center in Knox County.

The pilot project to establish the East Tennessee Foundation Youth Leadership Program has taken three years to complete. The program is designed to teach leadership skills to selected high-risk tenth grade high school students. It is comprised of two components: (1) a monthly seminar which teaches leadership skills and (2) student projects at individual schools.



Overholt

The program's focus is to provide students with the opportunity to interact with others outside of their school environment, building on their abilities to manage and overcome adver-

sities and to learn from each other. Since its completion, the project has been turned over to the Greater Knoxville Chamber of Commerce as a focus project.

Mrs. Overholt founded the Rule High School Parenting/Preschool Learning Center which is now recognized as a model program by the State of Tennessee. The Learning Center is designed to assist and teach adolescent parents and their children proper parenting and social skills. For establishing the Learning Center, she received an award from the American Home Economics Priority Issue Subcommittee on Single Parenting.

Though serving as president of the TMA Alliance during the past year, she makes time to continue her work as a consultant to the Knox County School System and the East Tennessee Foundation, as well as her volunteer work for the Salvation Army, the United Way, and the Fort Sanders School of Nursing.

Mrs. Overholt has received other awards for her volunteerism and community contributions including the University of Tennessee's Women of Achievement Award, the Beta Sigma Phi First Lady of Knoxville Award, the YWCA Tribute to Women Award, Humanities, and was chosen for the inaugural class for Tennessee Leadership in 1990.

Comprehensive Care Center of Nashville (CCC) is a regional organization dedicated solely to the treatment of HIV and AIDS patients from Middle Tennessee, Northern Alabama, and Southern Kentucky. The Nashville Academy of Medicine nominated the CCC for this year's Award in recognition of its ability to anticipate and accommodate the medical needs of these special patients.

The CCC opened its doors in 1994 under the direction of Dr. Stephen Raffanti. Dr. Raffanti came to Nashville in 1992 as associ-



Maier & Raffanti

ate professor of medicine at Vanderbilt University Medical Center and was the director of AIDS Services with Nashville's Metro Department of Public Health.

Soon he realized that Nashville lacked the proper facilities to care for the growing number of HIV/AIDS patients seeking treatment and alerted the mayor of Nashville. A task force was created to study the needs of Nashville and Middle Tennessee in 1993 and recommended that a comprehensive, outpa-

tient facility exclusively for the treatment of HIV/AIDS patients be established immediately. On that recommendation, a foundation was created that ultimately led to the opening of the CCC.

Due to the CCC's central location, it currently serves patients from 50 of Tennessee's 95 counties as well as patients from Alabama and Kentucky. Early projections estimated that the CCC would treat 600 patients during its first year. The Center exceeded its expectations and served 800 patients in its first ten months and 1,100 in the first 18 months. Currently the CCC receives 30 to 40 new patients a month.

In addition to medical services, the CCC addresses the educational, social, legal, emotional and spiritual aspects that the disease creates for patients. The award was accepted by Dr. Stephen Raffanti and Anne Maier. □



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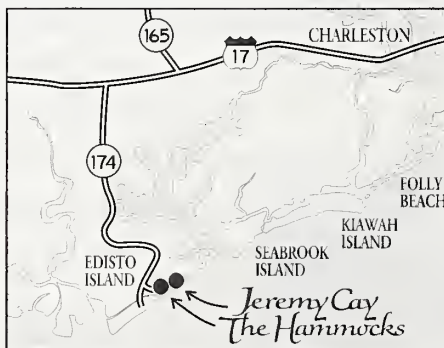
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TMA Annual Meeting Highlights Knoxville—April, 1996



Outgoing TMA President Robert E. Bowers, Chattanooga (left) turning over gavel to incoming president Dr. Richard M. Pearson, Memphis.



Medicine and Religion Breakfast speaker Rev. Kenneth Robinson, MD.



Dr. Yank Cobble, AMA Board member, addressed the TMA/TSIM Luncheon.



Newly elected president-elect Dr. R. Benton Adkins, Nashville (left) with Dr. John B. Thomison, Nashville, editor of Tennessee Medicine.



Dr. and Mrs. Richard M. Pearson and Dr. and Mrs. Robert E. Bowers enjoy the President's Evening.



Members found some time for fun at Egwani Farms to play in the Second Annual TMA Association Insurance Agency Golf Tournament.



Incoming president Dr. Richard M. Pearson addressing the President's evening guests.

1996 TMA ANNUAL MEETING — HOUSE OF DELEGATES COMPOSITION

FIRST SESSION: APRIL 11—SECOND SESSION: APRIL 14

EX-OFFICIO MEMBERS

OFFICERS

President	Robert E. Bowers, MD
President-Elect	Richard M. Pearson, MD
Vice-President	Sam J. Williams III, MD
Vice-President	Warren F. McPherson, MD
Vice-President	Neal S. Beckford, MD

BOARD OF TRUSTEES

David R. Barnes, MD	Present	Present
Virgil H. Crowder Jr., MD	Present	Present
James Chris Fleming, MD	Present	Present
David K. Garriott, MD, <i>Vice-Chairman</i>	Present	Present
William B. Harwell Jr., MD	Present	Present
Clark E. Julius, MD	Present	Present
Robert D. Kirkpatrick, MD	Present	Present
Michael A. McAdoo, MD, <i>Sec/Treas.</i>	Present	Present
Ronald E. Dyerfield, MD	Present	Present
Thurman L. Pedigo, MD	Present	Present
Charles T. Womack, MD, <i>Chairman</i>	Present	Present
Phillip E. Wright II, MD	Present	Present

COUNCILORS

1st District	Jere W. Ferguson, MD	—	Present
2nd District	John E. DePersio, MD	—	—
3rd District	Walter D. Parkhurst, MD	—	—
4th District	A. Austin Jones, MD	—	—
5th District	Theresa T. Morrison, MD	—	—
6th District	H. Victor Braren, MD	—	—
7th District	Malcolm A. Cox, MD	Present	Present
8th District	James D. King, MD	Present	Present
9th District	John W. Hale, MD	Present	Present
10th District	Patrick J. Murphy, MD	—	—

AMA DELEGATES

Charles Ed Allen, MD	Present	Present
Allen S. Edmonson, MD, <i>Chairman</i>	Present	Present
Hugh Francis Jr., MD	—	—
Francis W. Gluck Jr., MD	—	—
Clarence R. Sanders, MD	Present	Present

PAST PRESIDENTS OF TMA

John H. Burkhart, MD	Present	Present
J. Kelley Avery, MD	Present	—
David H. Turner, MD	Present	—
John B. Dorian, MD	Present	—
George A. Zirkle Jr., MD	Present	Present
Thomas K. Ballard, MD	Present	Present
James R. Royal, MD	Present	Present
James T. Galyon, MD	Present	Present
John B. Thomison, MD	Present	Present
Hamel B. Eason, MD	Present	Present
Charles W. White, MD	Present	Present

DELEGATES

EAST TENNESSEE GRAND DIVISION

County/Component Society			
BLOUNT	John J. Ingram III, MD	Present	Present
	Robert D. Proffitt, MD	Present	Present
BRADLEY	Nancy M. Blank, MD	Present	Present
	Stephen W. Jackson, MD	—	Present
CAMPBELL	L.J. Seargeant Jr., MD	—	—
CARTER	Tedford S. Taylor, MD	Present	Present
CHATTANOOGA-HAMILTON	L. Diane Allen, MD	Present	Present
	Ronald C. Brooksbank, MD	Present	Present
	Channappa Chandra, MD	—	Present
	Philip J. Dugan, MD	Present	Present
	Sharon Farber, MD	—	—
	John W. McCravy, MD	Present	—
	Frank J. Miller, MD	—	Present
	Terry Melvin, MD	—	—
	William E. Rowe, MD	Present	Present
	Jeanne Scanland, MD	Present	Present
	Molly R. Seal, MD	—	Present
	Charles W. Sienknecht, MD	—	Present
COCKE	Edward P. Capparelli, MD	Present	Present
CUMBERLAND	Robert Nichols, MD	Present	Present
GREENE	John C. Boys, MD	—	Present
	Ronald A. Cole, MD	—	—
HAWKINS	Charles D. Huffman, MD	Present	—
KNOXVILLE ACADEMY	H. Grady Arnold Jr., MD	Present	—
	Marjorie B. Barron, MD	Present	Present
	John H. Bell, MD	Present	Present
	Leon J. Bogartz, MD	Present	Present
	Leonard A. Brabson, MD	Present	Present
	John M. Burkhart, MD	Present	Present
	Peter W. Carter, MD	Present	Present
	David G. Gerkin, MD	Present	Present
	W. Don Horton II, MD	—	—
	Michael D. Kropalik, MD	—	—
	John W. Lacey III, MD	Present	Present
	F. Neal Peebles, MD	—	—
	Karen T. Rader, MD	Present	Present
	John D. Simmons, MD	Present	Present
	William F. Terry, MD	Present	Present
	George H. Wood, MD	Present	Present
LAKEWAY	Jim Barham, MD	—	—
	Charles S. Fulk, MD	Present	—
MCMINN	Clyde S. Martin, MD	—	—
MONROE	Eric A. Oefreitas, MD	Present	—
ROANE-ANDERSON	Elaine M. Bunick, MD	—	—
	Robert R. Casey, MD	Present	Present
	Mary Headrick, MD	Present	Present
SCOTT	Sven O. Spjuth, MD	—	—
SEVIER*	Richard Baker, MD	Present	Present
SULLIVAN	David R. Ginn, MD	Present	Present
	Edith Jarboe, MD	Present	Present

County/Component Society

		First Session	Second Session
	Thomas E. Mitoraj, MD	Present	Present
	Robert C. Patton, MD	Present	Present
	L. Dow Strader, MD	Present	Present
WASHINGTON-UNICDI-JOHNSON	David S. Archie, MD	—	—
	Burgin E. Dossett Jr., MD	Present	Present
	Jeff R. Farrow, MD	Present	Present
	Clarence E. Goulding Jr., MD	Present	Present
	Clarence E. Goulding III, MD	Present	Present
	Tara L. Sturdivant, MD	Present	Present
YOUNG PHYSICIAN SECTION		Present	Present
MIDDLE TENNESSEE GRAND DIVISION			
BEDFORD	Bruce M. Gipson, MD	Present	Present
BENTON-HUMPHREYS	Subhi D. Ali, MD	Present	Present
BUFFALO RIVER VALLEY	John B. Phillips, MD	Present	Present
COFFEE	Brahm D. Sethi, MD	—	—
DEKALB	Melvin L. Blevins, MD	—	—
DICKSON	Jeffrey S. Gordon, MD	—	—
FENTRESS		—	—
FRANKLIN	Kenneth G. Becker, MD	—	—
GILES		—	—
JACKSON	E.M. Dudney, MD	Present	Present
LAWRENCE	Norman L. Henderson, MD	Present	Present
LINCOLN	Fred Ralston Jr., MD	Present	Present
MACDON*		—	—
MARSHALL	Kenneth J. Phelps Jr., MD	—	—
MAURY	Thomas Wade Denney, MD	—	—
	Gaylon L. Harris, MD	—	—
MDNTGDMERY	George I. Kurita, MD	Present	Present
	W. Joel Pedigo Jr., MD	Present	Present
	R. Benton Adkins, MD	Present	Present
NASHVILLE ACADEMY	John B. Bond Sr., MD	Present	Present
	Reuben A. Bueno, MD	Present	Present
	Robert S. Collins, MD	Present	Present
	Jan S. Dalozier, MD	Present	Present
	Karen E. Duffy, MD	Present	Present
	Roy D. Elam III, MD	—	—
	John C. Frist Jr., MD	—	Present
	F. Anthony Greco, MD	—	—
	Perry F. Harris, MD	—	—
	Robert W. Herring, MD	Present	Present
	James M. High, MD	—	Present
	John E. Keyser III, MD	—	—
	John W. Lamb, MD	Present	Present
	Dana L. Latour, MD	—	—
	Russell B. Leftwich, MD	Present	Present
	Malcolm R. Lewis, MD	Present	Present
	David E. McKee, MD	Present	Present
	Frank A. Perry Jr., MD	—	—
	Ann H. Price, MD	Present	Present
	Ronald E. Pruitt, MD	—	—
	Barrett F. Rosen, MD	—	—
	Murray W. Smith, MD	—	—
	K. Shannon Tilley, MD	Present	Present
	John J. Warner, MD	Present	Present
	Ralph E. Wesley, MD	—	—
	Elizabeth K. Pfaffenroth (Student Delegate)	—	Present
DVERTON	W.G. Quarles Jr., MD	—	—
PUTNAM	Charles E. Jordan III, MD	Present	Present
	Randall Gary Samples, MD	Present	—
ROBERTSON	Paul D. Hartzheim, MD	—	—
RUTHERFORD/STONES RIVER	Susan T. Andrews, MD	—	—
	George L. Eckles, MD	Present	Present
	David L. Johnson, MD	—	—
SMITH	Hugh E. Green, MD	—	—
SUMNER	Lloyd T. Brown, MD	—	Present
	Ted W. Hill, MD	—	Present
WARREN	Wendall V. McCabe, MD	—	—
WHITE	Chet M. Gentry, MD	Present	Present
WILLIAMSON	Starling C. Evans, MD	Present	Present
	Joseph L. Willoughby, MD	Present	Present
WILSON	James C. Bradshaw Jr., MD	Present	Present
YOUNG PHYSICIAN SECTION	Steven G. Flatt, MD	Present	Present
WEST TENNESSEE GRAND DIVISION			
CONSOLIDATED	James T. Craig Jr., MD	—	—
	Donald McKnight, MD	—	—
	John H. Meriwether, MD	—	—
	Karl Rhea, MD	Present	Present
HAROLD	Robert A. Vegors, MD	Present	Present
HENRY	John O. Lay, MD	Present	Present
MEMPHIS-SHELBY		—	Present
	Rex A. Amonette, MD	—	—
	Joe P. Anderson, MD	Present	Present
	Allen S. Boyd Jr., MD	Present	Present
	Ann D. Brown, MD	—	—
	Nancy A. Chase, MD	—	—
	F. Hammond Cole Jr., MD	—	Present
	Nicholas G. Economides, MD	—	—
	George S. Flinn Jr., MD	—	Present
	Hugh Francis III, MD	—	Present
	Jerre M. Freeman, MD	Present	Present
	Charles R. Handorf, MD	Present	Present
	C. Eugene Jabbour, MD	Present	Present
	James Gibb Johnson, MD	Present	Present
	Robert E. Laster Jr., MD	Present	Present
	William L. Moffatt III, MD	—	—
	Evelyn B. Ogle, MD	Present	Present
	Phil E. Orpet Jr., MD	Present	Present
	Phillip A. Pedigo, MD	—	—
	Stuart M. Polly, MD	Present	Present
	John B. Rada III, MD	Present	Present
	William C. Threlkeld, MD	Present	Present
	J. Jeremiah Upshaw, MD	—	—
	Otis S. Warr II, MD	Present	Present
	George H. Wood II, MD	Present	Present
	Jesse C. Woodall Jr., MD	Present	Present
NORTHWEST TENNESSEE	H. Lebron Lackey Jr., MD	Present	Present
	James William Shore, MD	Present	Present
TIPTON	Warren A. Alexander, MD	Present	Present
YOUNG PHYSICIAN SECTION	James T. Batey, MD	—	—

Ex-Officio delegates serving in more than one capacity are listed only once. The above information was taken from attendance records signed by the delegates.

*The following component society delegates were not eligible for seating due to failure to file the 1995 annual report as required by the TMA Constitution and Bylaws: Macon, Sevier.

In Memoriam

Robert C. Christensen, age 80. Died March 25, 1996. Graduate of University of Michigan Medical School. Member of Sullivan County Medical Society.

James O. Fields, age 79. Died March 22, 1996. Graduate of University of Tennessee College of Medicine. Member of Consolidated Medical Assembly of West Tennessee.

Albert Brant Lipscomb Sr., age 76. Died April 7, 1996. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Cooper Holtzclaw McCall, age 84. Died April 3, 1996. Graduate of Johns Hopkins University School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

James C. Prose, age 77. Died March 26, 1996. Graduate of Tulane Medical School. Member of Knoxville Academy of Medicine.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

BUFFALO RIVER VALLEY MEDICAL SOCIETY

John B. Phillips, MD, Parsons

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

Daniel C. Grizzle, MD, Flintstone GA

Deanna R. Nabors, MD, Chattanooga

W. Michael Tew, MD, Chattanooga

Barbara M. Vealey, MD, Chattanooga

CUMBERLAND COUNTY MEDICAL SOCIETY

Christopher D. Climaco, MD, Crossville

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE

David Jacob, MD, Dyersburg

Susan S. Lowry, MD, Martin

KNOXVILLE ACADEMY OF MEDICINE

Gary L. Cooper, MD, Knoxville

Patrick M. Dooley, MD, Knoxville

LAKEWAY MEDICAL SOCIETY

Steven J. Addonizio, MD, Knoxville

Michael W. Bratton, MD, Morristown

Stuart E. Lowenkron, MD, Morristown

Sunil T. Ramaprasad, MD, Morristown

MAURY COUNTY MEDICAL SOCIETY

Karen L. Hunt, MD, Franklin

John O. Simmons, MD, Columbia

Richard G. Slade, MD, Columbia

Diana C. Talpos, MD, Spring Hill

MEMPHIS-SHELBY COUNTY MEDICAL SOCIETY

Herman A. Crisler Jr., MD, Memphis

Amy B. Stevens, MD, Memphis

MONTGOMERY COUNTY MEDICAL SOCIETY

David B. Birnbaum, MD, Clarksville

Noshir A. DaCosta, MD, Clarksville

NASHVILLE ACADEMY OF MEDICINE

Gregg P. Allen, MD, Nashville

Inez B. Bounds, MD, Nashville

Martha J. Butterfield, MD, Nashville

Stephen B. Cantrell, MD, Nashville

Jeremy H. Freeman, Nashville (student)

Edward S. Mackey, MD, Nashville

Kevin J. Myers, MD, Nashville

Kimberly A. Thomasson, MD, Nashville

Ellen P. Wright, MD, Nashville

OVERTON COUNTY MEDICAL SOCIETY

Vincent L. Fromke, MD, Livingston

PUTNAM COUNTY MEDICAL SOCIETY

Craig J. Maltman, MD, Cookeville

ROANE-ANDERSON COUNTY MEDICAL SOCIETY

Ramesh Dowray, MD, Oak Ridge

Paul J. Gurecki, MD, Oak Ridge

James E. Lynch, MD, Oak Ridge

SCOTT COUNTY MEDICAL SOCIETY

Mohammad El-Baba, MD, Oneida

SULLIVAN COUNTY MEDICAL SOCIETY

John R. Hereford, MD, Kingsport

Lidia L. Kao, MD, Kingsport

Thomas H. Price, MD, Kingsport

TIPTON COUNTY MEDICAL SOCIETY

Robert S. Lazar, MD, Covington

WILLIAMSON COUNTY MEDICAL SOCIETY

Daniel S. Weikert, MD, Nashville

Personal News

Jesse Cannon Jr., MD, Covington, has been elected to Fellowship in the American College of Physicians.

Pope B. Holliday Jr., MD, Chattanooga, received the Senior Pediatrician of the Year Award from the Tennessee Chapter of the American Academy of Pediatrics/Tennessee Pediatric Society.

Sarah H. Sell, MD, Nashville, one of only two women in her medical school class in 1944, received the prestigious Athena Award, recognizing her professional accomplishments and community involvement.

Stephen E. Woodley, MD, Kingsport, has been certified as a diplomate in medical oncology.

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during March, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Lisa A. Altieri, MD, Nashville
Susan H. Bryant, MD, Nashville
Ramon L. Carroll, MD, Jamestown
James P. Craig, MD, Elizabethton
Arlene J. Donowitz, MD, Chattanooga
Jordan W. Eggers, MD, Memphis
Charles T. Faulkner, MD, Nashville
Eddlyn A. Figueroa, MD, Jackson
John C. Frist, MD, Nashville
Julian C. Heitz, MD, Nashville

John D. Jones, MD, Brentwood
Rogelio D. Martinez, MD, Nashville
Sarada N. Misra, MD, Knoxville
Ronald E. Overfield, MD, Nashville
Howard C. Pomeroy, MD, Nashville
Samuel B. Rutledge, MD, Nashville
John B. Thomison Jr., MD, Nashville
Gregory R. Weaver, MD, Nashville
Ralph E. Wesley, MD, Nashville
Rodger J. Zwemer, MD, McMinnville

Board of Medical Examiners

Minutes - March, 1996

Name: Gordon Hoppe, MD (Greeneville)

Violation: Inappropriate prescribing and/or overprescribing.

Action: Per agreed order, license placed on probation for two years; must keep a log of all scheduled drugs; must maintain the advocacy of the Impaired Physician Program; must attend additional courses on prescribing medications to patients; may not take any new patients in his practice; must have an addictionologist or other appropriate specialist, on a consulting basis, review patient files.

Name: Alexander E. Horwitz, MD (Murfreesboro)

Violation: Overprescribing.

Action: Per agreed order, must permanently surrender DEA certificate; license restricted to his current role as a consultant to Student Health Services at Middle Tennessee State University; may not practice medicine in any other setting at any point in the future; must continue contract with the Impaired Physician Program; must attend the Tennessee Medical Association's overprescribing course.

Name: Karen J. Smiley, MD (Chattanooga)

Violation: Unprofessional and unethical conduct; pattern of continued and repeated malpractice and incompetence in the course of medical practice.

Action: License suspended pending her completion of a two-year ACGME accepted, recognized residency training program; must set an appointment with the Tennessee Medical Foundation and submit to an evaluation, if so recommended.

Name: John R. Wickman, MD (Cordova)

Violation: Violation of probationary agreement.

Action: Reprimanded.

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

Special Conferences/Seminars

Detailed brochures for the following courses are available. In some cases, registration numbers are limited.

July 15-19 Contemporary Clinical Neurology—Hilton Head Isl., S.C.
Aug. 8-9 Endoscopic Sinus Surgery and Revision Surgery Workshop
Aug. 15-16 1st Clinical Oncology Symposium
Sept. 25-28 Pulmonary/Critical Care Medicine—Destin, Fla.
Oct. 18-19 Laryngeal Video Endostroboscopy Workshop
Nov. 13-16 2nd Neonatology Symposium—Asheville, N.C.
Dec. 6-7 22nd High Risk Obstetrics Seminar

For information contact Division of CME, Vanderbilt University School of Medicine, D-821 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

Continuing Education Schedule

Memphis

July 22-27 Contemporary Issues in Obstetrics and Gynecology—Destin, Fla.

Aug. 17-22 Pharmacology of Thermoregulation

Sept. 19-20 28th Conference on the Mother, Fetus, and Newborn

Knoxville

Sept. 6 Hormone Replacement Conference

Sept. 15-17 Internal Medicine Conference—Gatlinburg

Oct. 11-12 Genetics Conference

Oct. 14-16 18th Obstetric Office Ultrasound Workshop

Oct. 28-30 16th Smoky Mountains Ob/Gyn Seminar—Gatlinburg

Nov. 15-16 New Concepts in the Treatment of Cardiac Disorders

Nov. 18-19 Pediatric Trauma Conference

Dec. 3-5 Perinatal Update '96—Gatlinburg

For information contact Mrs. Jean Taylor Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163, Tel. (901) 448-5547.

St. Thomas Hospital--Nashville

Continuing Education Schedule

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For information contact Registration Secretary, St. Thomas Hospital, (615) 222-2007.

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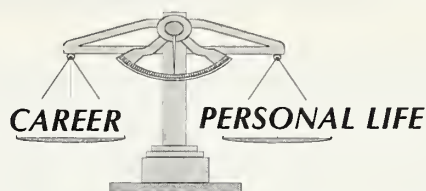
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Richard M. Pearson, MD

At the Front

Leadership is action, not position. This creates a difficult situation for leaders in times of great change, because simply holding on does not constitute adequate leadership. Physician leaders face this difficulty daily, and there is a temptation to feel that any action is more appropriate than holding the status quo. Movement in just any direction is not inherently a wise course of action, however. One can literally fall over the edge—just look at the lemmings.

Real physician leadership requires planning, goals, and strategies before movement. Physicians, both leaders and followers, must understand the difference between opinion and information. Good leadership and good planning rely on both, but blind opinion can never be a substitute for accurate information. Unfortunately, opinion comes easier than information. Like instant coffee, opinion doesn't require any picking, selecting, grinding, or brewing. All one needs is the hot water of anger, frustration, or ignorance to generate instant opinion. Being informed and having an opinion are thus two different states of being. What physician leaders should be seeking, and what physician followers should be generating, are solutions based on both good information and thoughtful opinions.

Physician leadership to a marked extent includes accountability. This is an issue that has changed dramatically in the past five years. The work of physician leaders has greater and greater consequences as their peers, many of whom are traditionally independent, are forced by society, business, and government into greater collective action. The wrong decision, seen in retrospect, has much greater impact than it did previously because both the stakes and numbers are higher. An MD degree qualifies us to be physicians, not leaders, administrative wizards, financial experts, or deft negotiators. These latter attributes have to be gained and earned outside the traditional physician training program. Organized medicine has consistently and successfully sought to broaden physician skills and roles while openly advocating for the patient and the preservation of the patient-physician relationship. Physicians who conduct themselves as business experts are going to be held accountable by their colleagues to professional business standards.

Good leadership tends to foster trust; trust tends to foster unity. Physician leaders must increasingly focus on what they and their fellow physicians have in common, not in the ways they differ. Demagoguery at this time in the history of our profession will be fatal to all of us. We all share training, traditions, values, ethics, and concerns for our patients' well-being. That alone is sufficient reason for moving forward together and speaking with one voice.

Physician leaders must remember that physicians alone are the true advocates and guardians of good patient care. That responsibility cannot be given away or diminished contractually. Medical ethics far exceed the ethics and values of the business world. This is a burden that we should gladly bear, for it clearly defines our choices and our course of action, and allows us to give rather than grasp.

Physicians increasingly speak for government and corporate structures. This is appropriate to the extent that the physician realizes and acknowledges that his credibility arises from the medical profession, not from his being a member of the corporation or the government. The physician has credibility because the public and medical colleagues perceive that personal values, ethics, and concerns reflect the medical profession and transcend employment.

Today a job title that doesn't provide stress will be eliminated. Today a "titled" physician who doesn't provide leadership and endure stress will be eliminated. Ethics, values, planning, accountability, and unifying action are all indispensable. The demands are great, but for all of us, generals and soldiers alike, there is no respite from the battle except in the midst of it. □

R. Pearson MD

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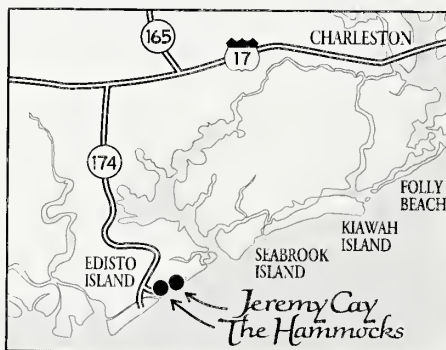
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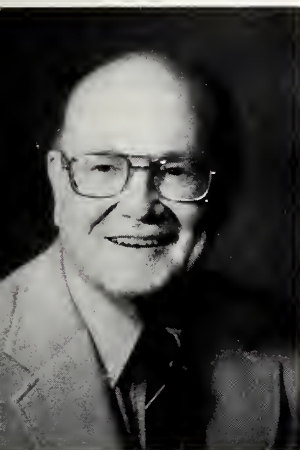
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John B. Thomison, MD

On Providing and Consuming

con-sume (kon-sum) *v.* **con-sumed, con-sum-ing, con-sumes.** *v. tr.* **1.** To eat or drink up; ingest. **2. a.** To expend; use up. **b.** To purchase for direct use or ownership. **3.** To waste; squander. **4.** To destroy totally; ravage. **5.** To absorb; engross.

Did you ever wonder what a mental health consumer is? Probably not, unless you happened to read the same front page story that I did in this morning's Nashville *Tennessean*. I can tell you that I had never wondered about it before, and having read the story, I can't say that I'm enlightened. I think I know what the speaker who used the term had in mind, but I'm not sure about that, either. I'm a little clearer on what would be meant by "mental health *provider*," though mental health services or care or what-not and not mental health are what are actually provided. (Some mental health care providers might have a quarrel with that, I guess.) But mental health *consumers*?

Think about it. Look at the definition of consume, and tell me how one consumes mental health. I suppose in a sense one could waste or squander it, as with alcohol or other drug abuse, but that is not what the speaker had reference to. The headline of the article says "Managed care trims hospital stays for mental illness." Like nearly everything that managed care does, the allowable treatment is inadequate or inappropriate, but this is not about that. The executive director of Mental Health Cooperative (not a physician) explained that "if a case manager learns that a *client* (emphasis added by me to show how these people think, or don't, as the case may be) is going through a bad episode, hospital care is not the automatic thought." (Of course not. Everybody knows *hospitalization costs money*.) "You can be psychotic and hallucinating and not be dangerous," she said. (See? Lo, the poor patient.) "Often they just need someone sitting with them. We put them in a motel room, provide food. They can stay one to three days. Usually the person with them is a mental health consumer. They understand a person in crisis." The reporter, not the exec, continues, "This round-the-clock observation until the episode subsides is called respite care. It's part of a trend accelerated by managed care's emphasis on cost cutting." (Lo, the poor caregiver-patient.)

Well, deliver me!

I shall refrain from commenting further on what I consider the deplorable non-care of the "clients," which looks to me a lot like putting the fox in charge of the hen-house, as well as on the grammatical deficiencies of the exec, since she was just being politically, if not grammatically, correct (it's seldom possible to be both), and stick to the item at hand.

Which is, who is this mental health consumer, and how does she do it? Does she suck it vampire-like out of her charge? I guess obviously not, since her charge hasn't any mental health to spare, if any at all. For her to consume it she must have a supplier. I can see that this is just leading us around in circles, and I can also see what one of "them" (i.e., those suppliers) might grasp at as a way out by implying, if not actually flat-out proclaiming, that they are indeed selling mental health and not just services.

To which I shall comment only that mental health is a scarce commodity, and not very many folks have much of it to spare. It also strikes me that Mental Health Cooperative is being mighty chintzy about turning loose of any. "The idea is to be more efficient, to only (sic) give people the care (note: *care*, not *mental health*; that's a whole 'nother ballgame, *n'est-ce pas?*) they need, no more, no less."

Sure.

Now, about that consumption of mental health . . .

I've coined a new term. It's a sub-category of New-speak called Slouch-speak. It'll doubtless never catch on, though, because most of those who use it wouldn't even understand what I'm talking about.

And then there's the TennCare mental health morass. But that's another story, too sordid to

even think about. All I can say is, "Hang on to all your faculties for all you're worth, or someone there will consume them for sure."

P.S. When I wrote this editorial, we—"we" being TMA—had not received Liz Garrigan's article on the Partners Program. In fact we knew little more than what appeared in the *Tennessean's* article, from which I quoted, and that was mightily little. It almost seemed—seems—a replay of the McWherter Administration's hanky-panky in re: TennCare. The only editorial comment I have to add in light of Ms. Garrigan's article or any other information we have received thus far about the program is: "See, what did I tell you?"

The Saga of Sunny: A Bicentennial Tail for the Fourth

With Independence Day coming up, it suddenly occurred to me that a Fourth of July editorial ought to be forthcoming. So here it is, sort of. I didn't really have that in mind when I started this, but when it came to me what issue I was working on (I frequently have trouble remembering that, considering our deadlines), I thought, "I've just been thinking about one who really values her freedom, and, like our forebears, isn't about to surrender it willingly. Why not that?" So here's her story, or the part of it I know.

For some months now this stray mutt has been wandering, and often frolicking, about Tennessee's developing Bicentennial Mall. From the photographs that have cropped up on occasion in the Nashville newspapers, the dog appears to be rather a higher than a lower class mutt, and since I can't attest to its pedigree or lack thereof, the term mutt might not even be appropriate. Whichever, the dog has been adopted after a fashion by workers on the Mall and by state employees, who are said to have named the dog Sunny out of deference, or something, to Governor Sundquist. I rather thought the name might have derived from the animal's disposition, which seems to be sunny, or from its lovely golden color, but what do I know? I'll take "their" word for it, "they" retaining their usual anonymity. But be that as it may, and despite the dog's disposition, it has steadfastly resisted, possibly wisely, all efforts at fraternization.

Though her human alleged friends might, indeed doubtless would, steadfastly deny that she was hardier and cannier than they, she has, or at least had at this writing, proved be so in numerous tests after she apparently was struck by a passing vehicle and painfully but not critically injured. Afterwards she continued limping about the mall, evading all helpfully motivated (allegedly) pursuers despite her injury, and defying tranquilizers fired from rifles and eaten in tasty morsels to bring her to heel. As some would-be captors sneaked up on her while she lay resting, perhaps woozily, in the shade, she was, according to the newspaper account (a half of the front page, with color photos, yet) "spooked by three *misguided* (emphasis mine) state employees, who clapped their hands and shouted, 'Run, Sunny, run!' " *Ummmmmm*?

Sunny took off, with one Mr. Jernigan, a Humane Association animal trapper with a tranquilizer gun, and the police and TV crews in hot pursuit, but again Sunny got the better of them. The Humane Association says it won't give up, and, because Sunny still needs treatment, or at least so they allow, and because she also might get hit again, they "will find her a safe home." Through all of this, Mr. Jernigan has become the most frustrated of men. In 13 years in the business, he says, "this is the first dog I've ever had any trouble trying to capture. I've thought about this day and night. If the animal gets run over again and dies this time, who's going to get the bad rap? Me, that's who."

A.....ha!

I don't wish to be misunderstood as questioning the commitment of Mr. Jernigan in particular, or the Humane Association in general, for whom I have the utmost respect, to the animals

they serve, or to Sunny, but I somehow get feelings of *deja vu*. It brings to mind the host of doctors in the early days of penicillin therapy who, when questioned as to the propriety of having given the drug to a particular patient would respond, "Well, sure, the patient didn't really need it, but he *wanted* it, and if I hadn't given it to him, he would have found himself another doctor. And it didn't hurt anything, did it? So I figured it might as well be me." And then I think of all the feral creatures who die simply from being confined in captivity. I think of the homeless hobo I took care of when I was a surgical resident at Erlanger Hospital in Chattanooga in 1947 who when he died left an estate of several hundred thousand dollars. And I think of the aged, penurious Mary Northern, who wished to take her gangrenous feet with her to the grave—soon—but was not allowed to. She did go to her grave, but not very soon, and not until a plethora of do-gooders, the courts, including the United States Supreme Court, who much too late said leave her be if that's her wish, and a massive, lurid coverage by intrusive news media, especially TV "investigative reporters," had treated a sensation-hungry public to a protracted Roman carnival at her expense.¹

Not everybody or everything wants a safe home, or even safety of any kind, especially if it comes at the price of chains and slavery. ("Forbid it Almighty God," exclaimed Patrick Henry in proclaiming what it was the 13 American colonies should achieve by rebelling against their mother country more than 200 years ago. Though some of their progeny still cling fiercely to those aspirations, others have altered them perceptibly, I think. But not Sunny.) Not everybody wants to live forever, at least not in this world, and especially if it means a life without dignity. God never intended it so, having imposed limits that modern technology has managed to circumvent on occasion, at least temporarily.

Apparently Sunny knows more of the Spirit of '76 (1776, that is!) than most of those around her, with the possible exception of those three poor, misguided state employees, and some others like them, who helped her escape. Sunny is a product of the streets. Put her in that safe home, and you can bet on her first night (or day) out Sunny will present to her new keepers a last rear view, with a wagging bicentennial tail behind her.

Some of our do-gooders, public, corporate, and private, and especially some of our self-styled watchdogs, including some jurists, need to take a lesson from the Saga of Sunny. All some folks want is to be left alone. All some of them want is to be left to die in peace, with dignity. Not many of them want to be meddled with to the extent we have become capable of, and, God help us, accustomed to, meddling with them. Some still find life not all that dear—no, nor peace that sweet.

1. Thomison JB: Mary Northern's feet. *J Tenn Med Assoc* 71:388-389, 1978.

The Once and Future Annual Meeting

Then slowly answered Richard from the Board,
"The old order changeth, yielding place to new . . ."

with apologies to Tennyson, *Idylls of the King*

Ordinarily the drive from Nashville either eastward or westward to the Annual Meeting is graced by a riot of springtime color. But not this year. The return trip gave a hint of better things to come, as a few dogwood had begun showing some white blossoms, but the trees were already in full leaf, and the white often scarcely showed through. All in all it was a rather unsatisfactory spring, if one can call it that, since the weather seemed to rock back and forth from winter to

summer and back again without spring's moderation.

Whether or not the weird weather pattern had any bearing on the poor attendance at the meeting in Knoxville is an imponderable. There are indications in both directions. Certainly the attendance has steadily dwindled over the past few years. On the other hand, the Dogwood Festival has traditionally drawn a goodly crowd to Knoxville, and though the festivities were there, the spring color was not. Instead, a cold, dreary landscape greeted the attendees, such as there were, and many apparently simply stayed home. For whatever reason, an attendance that has been low for some time just got even lower.

If you take a peek at the way the Annual Meeting has been diddled with over the past few years in an attempt to boost the figures, you find the verity of the axiom that nothing ever stays the same. I had been under the impression until then that though few things are set in stone, the makeup, and particularly the timing, of that meeting was. The House of Delegates always convened during the first or second week in April unless Easter got in the way, when it might be postponed until the third week. (One year not even Easter deterred it. That caused such a stir that no one would ever claim responsibility, and it most assuredly will never happen again.) In any case, some basic research showed that timing of the meeting is merely custom, and not law at all, as had been assumed. The Annual Meeting can happen at any time.

Several years ago the House began indicating its displeasure about not only the timing of the meetings, but the length as well, as it was costing the busy practitioners about a week of their time, running as it did Wednesday through Saturday. A trial at shortening it a day proved to be of no help, and so it was next changed to run Thursday through Sunday. Judging from attendance, or rather lack thereof, that change was not very popular, either. To compound the difficulty, many of the specialty societies ceased patronizing the Annual Meeting, and others have it in mind, meeting separately at another site. Before continuing to make more changes unilaterally, at this meeting the Board of Trustees polled the membership of the House of Delegates, and learned that the majority favored a purely business meeting, to be conducted on Friday and Saturday. After determining that the commitments for time and space could be altered without penalty, it was so ordered by the Board on a trial basis for one year. The Board was guided in its decision by President Pearson, whose meeting it will be, on the premise that should it turn out to be a bad idea it would not bungle anyone else's turn.

The 1997 Annual Meeting will have another first, or at least a first for recent times. It will be held in Chattanooga for the first time in a number of years, initiating a change in rotation that will eventuate in the meeting's no longer being held in the president's home territory. No one considers that a hardship, since for practical purposes the president's duties are such that he is "out of town" wherever the meeting is held.

It will be interesting to see what effect all this has on attendance at the meeting. In the first place, it will offer little excuse for the delegates and their alternates to miss the meeting, making allowances, of course, for occasional extenuating circumstances. Every delegation should, therefore, expect to have its full quota on the floor of the House at all times. We shall see. In the second place, everyone should note that this arrangement does not preclude the concurrent meeting of specialty societies. It will simply mean that there will be few official TMA functions other than the House of Delegates and meetings of the TMA Alliance. The TMA will not be responsible for making arrangements for lodging or meeting space for the specialty societies as it has done for many years. I feel certain, however, that the staff will not turn a deaf ear to any reasonable request for help from TMA members. It is also not outside the realm of possibility that TMA will in the future hold educational assemblies apart from the Annual Meeting, as is presently done in a number of states.

Keep in mind that your Association is attempting to restructure itself and its functions to meet the needs of you, its members, and to be sufficiently flexible to alter its operation quickly as the need arises in our rapidly changing practice climate. It can meet your needs only to the extent you make them known. Your officers, Board of Trustees, and staff need your constant input. Talk to us!

To Be or Not To Be . . . That Was Just One of the Questions

Russ Miller

Sr. Vice President, Communications

It's been three months since the *Journal* evolved into *Tennessee Medicine*. For those of us on staff and the physician members of the task force it seems more like three years since we first looked at the *Journal* and gave serious thought to changes and improvements, which we hope the members of TMA appreciate.

Before I go any further, we truly want your feedback. The evolution of *Tennessee Medicine* and its ultimate success depends on your input. We have come this far with the help of the 581 members who answered our readership survey in 1995, the advice of the task force, and the wisdom of our consultants, Dye, Van Mol and Lawrence, but if the members are not happy or do not think *Tennessee Medicine* is of value to them personally, then we have failed in our mission.

Many may ask "why did you change the *Journal*?" TMA is simply responding to the needs and wants of its members. In 1995, the Communications and Public Service Committee evaluated how the Association communicated with its members. It studied the *Chart*, the *Journal*, *Legistat*, direct mail, fax networks, videos, conference calls . . . all means by which TMA has used to keep you informed. While changes have come about in other TMA communications tools, we know the greatest potential lies within the *Journal*, both for success and failure.

The greatest challenge for the task force was to take a highly visible, revered, and respected publication, and make changes to its design and content that would invite new readers while not alienating current readers. The solution was to update the graphics and add new timely content to the scientific portion of the *Journal*.

Take note that the name of the publication is "*Tennessee Medicine—Journal of the Tennessee Medical Association*." This is for a reason. It remains the *Journal* with new information on topics that you, the member, said you would like to read.

There is a second reason for change. Gathering more consistent readers is goal one. The second goal is to pay for our changes through increased advertising revenue. As Dr. Thomison wrote in his editorial about the format change in March,¹ it takes money to print and mail *Tennessee Medicine* and money sources tend to be drying up of late, as were our options for the *Journal*.

When I titled this article "To Be or Not To Be," I was not trying to be cute. The situation had become serious and something had to be done. I personally believe we made the right move and am proud to have been a part of this project. With your help, *Tennessee Medicine* will continue to evolve and become the foremost publication about practicing medicine in Tennessee. Let us hear from you.

1. Thomison JB: Housekeeping. *J Tenn Med Assoc* 89:95-96, 1996.

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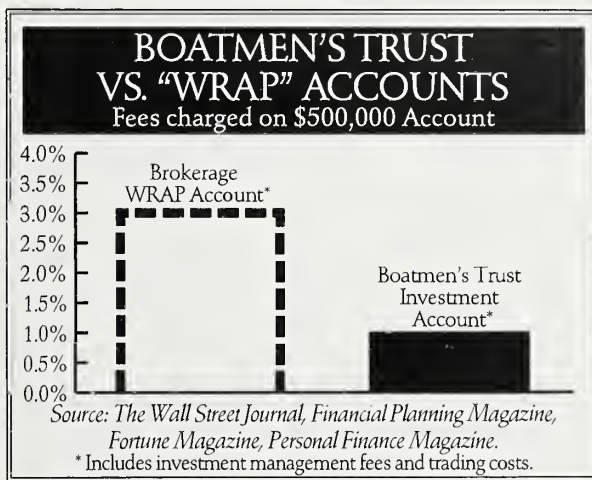


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TennCare BHOs

Partners Program Startup Mirrors TennCare; Mental Health Patients Lumped Into Two Plans

Liz Murray Garrigan

Tennessee is once again venturing into relatively unknown territory as it prepares for a July 1 launch of a \$350-million managed care program that will act as a sort of rider to TennCare.

The so-called TennCare Partners Program will carve out mental health and substance abuse services from the \$3.3-billion TennCare program and rely on two managed care groups known as behavioral health organizations, or BHOs, to deliver the specialized care.

In addition to their current assignment or choice of managed care organizations (MCOs), the Tennessee Department of Mental Health and Mental Retardation will assign all 1.2 million TennCare enrollees to one of the two BHOs. Each head is worth a monthly capitation of roughly \$22, lower than the \$118 the MCOs get, but it reduces the amount of money paid to MCOs for other health care services by \$7.53.

One reason offered for the TennCare expansion is to relieve the fragmentation of services and, in some cases, the criticism aimed at TennCare. Both outpatient and inpatient mental health care have been provided by the TennCare MCOs, but not all of them deliver the services themselves. Some contract with BHOs to deliver the care, making it difficult for TennCare patients to know whom to talk with about services.

Some believe separating state dollars for mental health care from all other TennCare services will help the state control costs.

Liz Murray Garrigan, formerly a reporter for the Nashville Tennessean and a health writer for the Nashville Business Journal, is a political correspondent for M. Lee Smith Publishers and The Tennessee Journal.

Premier Behavioral Systems of Tennessee

TennCare Partners Crisis Line: (800) 809-9957
 Information: (800) 325-7864
 Corporate Address: 222 2nd Ave. North, Suite 220
 Nashville, TN 37201
 Claims: Foundation Health
 3 Maryland Farms, Suite 200
 Brentwood, TN 37027

Tennessee Behavioral Health, Inc.

Information: (800) 447-7242
 Fax: (423) 470-7678
 Corporate Address: 1420 Centerpoint Blvd.
 Knoxville, TN 37932

"In the traditional managed care world, there's not much understanding of mental health issues," says Ann Carr, lobbyist for the Tennessee Psychiatric Association and the Tennessee Association of Mental Health Organizations. "By segmenting funds earmarked for mental health services, mental health care providers will be better able to control costs and ensure a high quality of care over the long term," she says.

But the Partners Program is much like TennCare was

when it started in 1994—mostly untried and untested. Other states have carved out mental health services for indigent patients, but the jury is still out on the effectiveness of the programs.

"Managed care for mental health is still a new and evolving field," says Trish Riley, executive director of the National Academy for State Health Policy. She says many states have tried the concept Tennessee is about to undertake, but each program is different.

Arizona, for example, contracts with six nonprofit mental health provider groups to operate regional networks of care. The state served more than 100,000 people in 1995 with a budget of about \$250 million, but officials there say that's not enough to allow patients to live independently and successfully on their own.

Tennessee's goal, though, isn't necessarily to allow people to live on their own. A large percentage of patients who will be served by the Partners Program will be those already institutionalized in the state's five developmental centers for the mentally retarded. Another group will be people served through 29 community health centers.

Funding

About \$100 million of the Partners Program budget will come from the existing TennCare budget by reducing by \$7.53 a month the capitation being paid to the MCOs for mental health services. The rest will come from the state Department of Mental Health and Mental Retardation, which already pays for the most severely impaired non-TennCare enrollees.

Ben Dishman, deputy commissioner of the department, says that mental health care spending will increase but that it will be offset by an increase in federal money from the Health Care Financing Administration (HCFA), the agency responsible for approving the supplemental waiver to allow Tennessee to move forward with the Partners Program.

Formularies

Physicians and advocates for the mentally ill are hoping this TennCare carve out, which includes pharmacy and laboratory services, will mean expanded formularies to treat patients. As it stands, some drugs commonly used in the commercial sector—Prozac and Paxil, for example—are not included in the TennCare formularies. But the TennCare Bureau will have to approve the new formularies for the Partners Program.

Formularies have been a problem in other states. In Iowa, where mental health services were contracted to MCOs, approval has proved difficult for expensive medications. For example, doctors had a hard time approving prescriptions for Clozaril, used to treat schizophrenia.

"I think managed health care does mean less services," says Margaret Stout, executive director of the Alliance for the Mentally Ill in Iowa. "I don't think it's the intent, but I think it is translating into that. It will be more difficult to access the system for the first time."

TMA Perspective

TMA officials have met with representatives from the BHOs, MCOs, and the state to find out more about the Partners Program. They walked away concerned that the BHOs

and MCOs will decide the operation of the program with little input from even the state apart from financial directives.

"We have reviewed the TennCare Bureau's draft rules on the Partners Program and they are completely bare bones—no substance whatsoever," a memo from TMA President Dr. Richard Pearson to other TMA officials says. "So whatever the BHOs and MCOs work out will be the Partners Program."

Pearson learned the BHOs and MCOs had formed committees to negotiate the Partners Program policies on such things as management information systems, pharmacy issues, and network issues. Volunteers from the TMA Board of Trustees and other TMA members are being asked to serve as consultants to the committees, which are actively seeking TMA's input.

In a letter to TennCare Partners Program Medical Director Dr. Robert Fisher, Pearson asked that the program implementation be delayed until August 1 so that TMA's suggestions can be heard and considered.

"Once again the state will expect, perhaps by default as occurred with the previous administration, that the TMA will assist it in educating physicians about this latest waived program," Pearson writes. "We are racing to do just that, albeit far too late to accomplish the task as needed."

Questions Pending

With the July 1 startup, questions still abound about the Partners Program. Chief concerns are clarifications of rules regarding reimbursement for non-mental health professionals providing patient services; how BHOs intend to sign contracts with a substantial number of physicians; and potential problems that may occur when patients are in need of mental health services and there is a conflict between their MCO choice for TennCare and Partners. TMA's call for more time is appropriate, given the startup experience with TennCare. "We simply must have more time and cooperation to seal the obvious cracks in the Partners Program. Otherwise, the system will again place the entire burden of the program on patients and providers," said Pearson. □

LATEST WORD

At press time, here is what TMA has learned through additional meetings with the state, the MCOs, and the BHOs.

- Premier plans to offer a sub-capitation arrangement for reimbursing primary care physicians (PCPs) that provide mental health care. In such an arrangement, PCPs will not directly contract with the BHO, but will continue to be reimbursed by their MCO. The MCO will then seek to re-coup fees from Premier.
- TBH, contrary to TMA's recommendation, will attempt to directly contract with PCPs despite a short implementation timeframe. MCOs will reimburse physicians for the first patient visit, with the BHOs paying for subsequent visits, each being subject to prior approval.
- The BHOs are striving to have physician contracts and clinical guidelines ready for distribution on June 15. TMA has been granted advanced copies of these guidelines and contracts for review and comment.
- Sixty percent (60%) of TennCare patients will be assigned to Premier, and forty percent (40%) to TBH. The BHOs are expected to use the RxCare formulary, possibly expanding it in the future.
- TMA representatives have scheduled additional meetings with BHO officials the weeks of May 30 and June 12 to hopefully learn more about all finalized details.

Where Did All the Specialties Go?

Managed Care Trends Steer Tomorrow's MDs Into Primary Care Slots

Tim Sewell

Two family practice residency programs opening July 1 in Chattanooga have had no trouble filling 20 available positions, while an established anesthesiology program in Memphis has had difficulty filling five positions.

According to education officials, that's simply a reflection of the nationwide trend in which more medical school graduates are opting for careers in primary care.

"With the move toward managed care and the national push toward primary care, it's no surprise that more medical school graduates are entering the primary care residency programs," says Mary Ann Watson, assistant dean of graduate medical education at the University of Tennessee, Memphis. "What's happening in Tennessee is no different than what's happening across the nation. Medical students are getting all sorts of incentives to go into primary care."

According to the numbers released March 20 by the National Resident Matching Program, for the second year in a row more than half of U.S. medical school graduates will pursue training in one of the primary care disciplines. Meanwhile, the number of students entering such specialties as anesthesiology and diagnostic radiology has dropped significantly.

Of the 14,539 U.S. medical school graduates participating in this year's match, 54.4% are entering residency training in one of the primary care disciplines. Of those graduates, 2,276 will enter family practice residencies this year, a 9.4% increase over last year's record number of 2,081 first-year family practice residents; 3,419 will enter internal medicine residencies this year, a 2.9% increase over last year. Pediatric residencies showed a 6.1% increase over last year's numbers, 1,593 medical school graduates matching to fill these positions, and set-

"With the move toward managed care and the national push toward primary care, it's no surprise that more medical school graduates are entering the primary care residency programs."

—Mary Ann Watson
Assistant Dean of Graduate Medical Education
University of Tennessee, Memphis

ting an NRMP record for first-year residents pursuing training in this specialty.

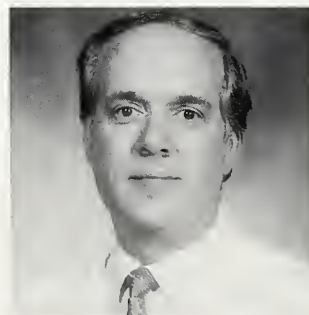
One way that Tennessee is responding to the challenge of training more primary care physicians is through the development of new family practice residency programs. Two programs—one operated by East Tennessee State University and one by the

University of Tennessee—will open this July in Chattanooga.

Shirley Ellis is the residency coordinator for the ETSU family practice residency program located at Chattanooga Memorial Hospital. That program will open with 12 residency positions—six first-year positions and six second-year positions. In 1997, the program will add six third-year positions, bringing the total number of residency positions to 18.

"With all the changes in health care, and everything becoming more oriented toward managed care, there just aren't enough primary care physicians," Ellis says. "The hospital and the university formed this program to address that need as well as the need for more primary care physicians in this part of Tennessee."

Dr. J. Mack Worthington, director of the UT family practice residency program located at Erlanger Medical Center, agrees that Chattanooga was the logical place to start a new



Worthington

family practice residency program. "When you compare Chattanooga to cities like Knoxville and Memphis, it's obvious that there is a great need here for primary care," Worthington says. "With the two programs here, I'd say the only other place we might add family practice residency positions would be in Nashville

Mr. Sewell is a reporter for the Memphis Business Journal and writes frequently for the Memphis Health Care News.

and Middle Tennessee, perhaps through Vanderbilt."

The UT family practice residency program is opening July 1 with six first-year residents and two second-year residents. Ultimately, the program will include 24 residents, with eight first-year residents admitted to the program each year.

According to Worthington, the UT program received its accreditation at the end of January, and therefore didn't get to participate in this year's match. "We had a number of people who looked at us," Worthington says. "But, at that point, we had to tell them that we had only applied for accreditation, and that accreditation was still pending. Now, we're looking forward to doing the match next year."

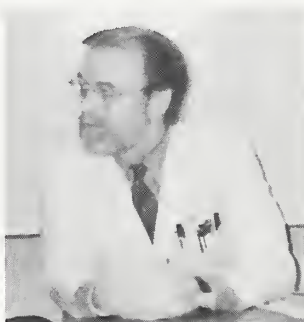
The ETSU program was accredited in September, and if the results of the ETSU match are any indication, UT should have no problem filling its positions through the match. "We listed only five first-year positions with the match because we had contracted with one other resident not in the match," Ellis says. "Of those five, we matched with four. We had one position open after the match was announced and we filled that position by 6:00 that night."

"We really didn't know what to expect from the match," Ellis adds. "We thought that a lot of residents might be hesitant to go into a new program, but I think because of the reputation of our program director (Dr. Thomas A. Cable) we were able to get some very highly qualified residents."

Dr. David E. Roberts serves as the director of one of the older family practice residency programs in the state. That program, affiliated with UT and located at the Family Practice Center in Jackson, includes 24 residency positions, with eight residency positions opening each year.

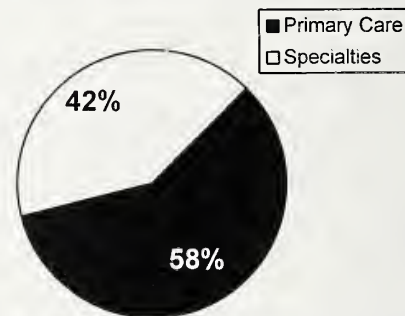
Roberts has been serving as director of the Jackson program for approximately one year. He has served on the UT medical school faculty for 15 years. He points out that over the past five years or so there has been a significant increase in the number of family practice residency programs throughout the United States.

Because Tennessee began developing new programs earlier than some other states, the rise in the number of medical school graduates entering family practice residencies in Tennessee hasn't been as dramatic as in some other parts of the country, Roberts says. "The rise has been more gradual here, although I think it's fair to say that the number of UT medical students choosing careers in family practice has risen a little more than 10% over the past five years," Roberts continues. "Even though we have increased the numbers, there is still a pretty good demand for family practice because we



Roberts

Primary Care* vs. Specialty Match



*Includes Family Medicine (17.7%), Pediatrics (12.5%) and Internal Medicine (28.1%)

are just basically keeping up with attrition."

Roberts says that as more medical school graduates opt for family practice and other primary care specialties, the competition for available residency positions will become more intense. Still, he says he doesn't foresee any new family practice residency programs being formed in Tennessee in the next few years.

"I think we're fairly well positioned in Tennessee at this time with regard to residency programs," Roberts says. "If anything, I think we're in danger of overestimating the need for the number of primary care physicians, and we need to carefully factor in the impact that managed care and physician extender practitioners will have. It's important that we have the right number of positions, but we shouldn't overdo that or we'll be in the same position as the specialists."

While the number of family practice residency programs has grown to meet an increased demand, some specialty programs have had difficulty filling available positions due to a lack of interest. In this year's match, anesthesiology and diagnostic radiology were hit particularly hard. For instance, only 43 U.S. medical school graduates will enter first-year anesthesiology residencies this year, a 53.8% drop since last year, when 93 graduates were matched to these programs. The number of medical school graduates securing second-year residency positions in anesthesiology dropped 61.8%. Only 243 U.S. medical school graduates will enter first-year diagnostic radiology residencies, a 26.6% decline from 1995, when 331 graduates matched to these programs. The number of medical school graduates securing second-year residency positions in diagnostic radiology dropped 20.3%.

Dr. John Zanella is chairman of the department of anesthesiology at the UT Memphis College of Medicine and director of the university's anesthesiology residency program. That program, which has been operating since the late 1950s, is a four-year continuum program, meaning that the resident spends one year in basic science and three years in anesthesiology.

The anesthesiology residency program at UT Memphis has 15 positions, with five first-year positions open each year. So far, only one of those positions has been filled.

"Because of the way our program is set up, we matched this year for a year from July," Zanella says. "We hope that, over the next year, we will pick up a number of individuals who are doing a clinical year who may change their mind or who may switch from another specialty. Traditionally, we have gotten about half of our residents like that."

Zanella has been with UT since 1979. He has served as chairman of the anesthesiology department for almost six years. He notes that the anesthesiology residency program was reduced from eight new positions each year to five in 1995. That was due more to the effects of TennCare on graduate medical education funding than on the low number of medical school graduates entering the program, he says.

The anesthesiology residency program at UT Memphis is one of three programs in the state. Those programs had a total of 23 anesthesiology residency positions open this year. Only three of those have been filled, Zanella says.

"Certainly, the push for primary care physicians is reducing the number of people who are looking at specialties, including anesthesiology, so the number of applicants consid-

ering the specialty has decreased," Zanella says. "Some of the manpower studies that have been conducted have shown that, if we continued to produce anesthesiologists at the rate we were, or even if we cut back, there would be surplus of anesthesiologists."

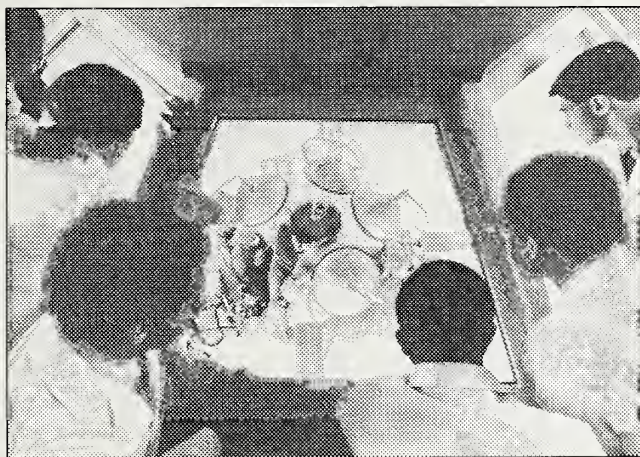
Ironically, anesthesiology was the fastest growing specialty in the 1980s. The number of medical school graduates entering anesthesiology began to drop off in the early 1990s, Zanella says.

"The new reality is such that everyone is unsure what reimbursement levels are going to be and what the job market is going to be," Zanella says. "And it seems like the national thrust is to reduce the number of specialists and encourage more primary care physicians."

Zanella notes that most of the national committees have recommended limiting, and in some cases reducing, the number of specialty residency slots.

"In my opinion, it's a moot point whether we reduce the slots in anesthesiology if there are no applicants," Zanella says. "People talk about the power of the marketplace. I feel like we've seen an overreaction with the results of this year's match. If that continues uncorrected, it may lead to a shortage of anesthesiologists in the future." □

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Loss Prevention Case of the Month

Difficult Diagnosis

J. Kelley Avery, MD



Dr. Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

A 34-year-old woman had a long history of Crohn's disease involving the colon, with fistula formation. Two years before the present illness, the patient was under the care of a gastroenterologist for an exacerbation of her illness. With her disease improved for about 18 months after a regimen that included oral prednisone and IM methotrexate, she became pregnant and reported to her obstetrician for routine prenatal care in early December.

Her last menstrual period was reported to have been in mid-April. The urinary chorionic gonadotropin test was positive and her EDC was calculated to be July 20. On her prenatal record the history of Crohn's disease was recorded, along with the name of her gastroenterologist. She had had a low-grade urinary tract infection, which had been treated successfully by another physician. She had no nausea or vomiting, and her abdomen was reported as normal. The course of her pregnancy progressed without incident. The OB ultrasound about six weeks after her first OB visit and a repeat at 24 weeks gestation were reported as entirely normal.

Two weeks after that visit to her obstetrician she reported to the community hospital with right lower quadrant pain that had started about 12 hours earlier. Her vital signs were

not remarkable and the fetal heart tones (FHTs) were heard and recorded at 120/min. The pain continued in the emergency department (ED) and she volunteered her history of Crohn's disease but stated that her "pain does not feel like that." She was having difficulty moving on the stretcher and stated that it felt like "muscle spasm." The obstetrician on call for her OB group ordered some routine laboratory work and authorized Stadol to be given in the IV that was running at a "keep open" rate.

The laboratory report, which included electrolytes, liver function studies and blood counts only, showed a WBC count of 12,500/cu mm, with 85% segmented neutrophils. Her blood pressure remained at 115-120/72-78 mm Hg while she was in the ED, and she reported that she "felt better after the medicine." Reexamination of the abdomen at this time revealed no tenderness. Both she and her husband were reassured and were allowed to go home. She had been observed in the ED for almost five hours. Four days later she was seen in her obstetrician's office complaining of "severe abdominal pain." Again the patient and the physician thought the pain was musculoskeletal in nature. A urinalysis was done, some codeine given for pain, and the patient was sent home to be examined in a week by her obstetrician.

She was seen by her obstetrician at the regular appointment one week later. There were apparently no abdominal symptoms, the urine showed a 1+ protein, and the examination was negative. The patient was to return for her regular visit in two weeks, but five days later her obstetrician refilled by phone the codeine prescription for abdominal pain.

Three days later, at about 28 weeks gestation, she was taken to the ED by ambulance complaining of severe "sharp" pain in the abdomen. She had a fever of 100.4°F and some vaginal spotting. She was nauseated, but had not vomited. She gave a history of pain in her abdomen for about a month, but since early morning the pain had been occurring about every 15 minutes.

She was sent to the labor and delivery suite, where her abdominal pain continued and she began complaining of pain in the right chest, with difficulty breathing. Three hours after this admission to the ED her fever was 102.4°F. The FHTs were 120/min but there was thought to be some variable de-

crease. Believing that the patient was having some emergency condition associated with her pregnancy, her obstetrician performed a cesarean section. When the abdomen was opened about a "quart of pus came out." The uterus was opened and a 2 lb 8 oz male infant who seemed to be healthy except for the prematurity was delivered. The abdomen was full of pus, with very heavy adhesion formation throughout. A blown out appendiceal stump was identified, and the surgeon speculated that it had been ruptured for 10 days to two weeks. She was noted to be bleeding from every surface, and there was a noted lack of clotting of the blood. Laboratory studies confirmed the diagnosis of disseminated intravascular coagulation. She was transfused with quantities of fresh frozen plasma and whole blood. The operation was completed with the closure of the skin incision and the patient, who "looked more stable," was transferred to the intensive care unit.

The patient's condition remained critical with hypotension, tachycardia and fever, and she was thought to be in septic shock. Antibiotic coverage, begun in the operating room, was continued, but the WBC count rose to 87,000/cu mm, and a maculopapular rash appeared. The sequence of events was thought to be acute appendicitis with rupture and gram-negative sepsis. Blood culture confirmed this impression. She seemed to remain neurologically alert but developed purulent pleural effusions bilaterally. CT of the abdomen showed a very large collection of fluid extending from the left lateral subdiaphragmatic area down to the pelvis. Drainage of this fluid yielded 400 cc of purulent material followed by a comparable amount of frank blood. The surgeon believed that in attempting to remove what appeared to be a pleural effusion, the diaphragm had been opened and that the fluid came from the abdomen.

The patient began to develop multiple organ failure, with the heart becoming enlarged, the lungs showing evidence of congestive failure, the urinary output falling, and the BUN/creatinine rising. Renal dialysis was considered, but the patient was thought not to be a suitable candidate. She continued to go downhill, and died some three weeks following the operation.

Despite some evidence of hyaline membrane disease, the infant was able to leave the hospital in good condition at 20 days of age.

Loss Prevention Comments

It is obvious that a deadly delay in diagnosis of acute appendicitis occurred in this case, but to make such an error in judgment is not medical malpractice! With the history of Crohn's disease, the physicians who cared for this lady were led away from the real diagnosis. There was a willingness to attribute the pain to "musculoskeletal" origins rather than to look further. She was given narcotics on her first visit to the

ED at a time when she had an elevated WBC count and a shift to the left on differential count. There is no mention in the ED records of a thorough abdominal examination except for references to the pregnancy, and the statement after narcotics had been given that the abdomen appeared "normal." On the second visit to the ED, she was said to be having "severe abdominal pain," but again with no mention of an abdominal examination except for the pregnancy. No blood was drawn for a WBC count and differential. Codeine, which had been prescribed shortly after the first ED visit, was continued. There was a telephone refill of the codeine without a visit after the second ED evaluation. Obviously, the narcotics masked the pain in the abdomen which could have led to earlier intervention.

It looks very bad for our physicians, but given the history of Crohn's disease and some treatment of that condition with methotrexate and prednisone (we have no information as to how long before the pregnancy these drugs were stopped), there was plenty of room for confusion as to the real problem. It is hard enough to make an early diagnosis of acute appendicitis at this stage of pregnancy without the complication of a history of Crohn's disease.

However, the patient said all along that her pain did not feel like the pain she had experienced with the acute stage of her Crohn's disease, and in retrospect this statement should have played a greater role in the consideration of acute appendicitis as a primary diagnosis. The failure to listen to the patient, to consider as important the elevated temperature and WBC count, and the masking of the abdominal pain with narcotics were thought to be sufficiently serious deviations from the accepted standard of care to warrant a settlement in this case. There was also a very large medical expense bill, and a father left with a small baby to care for. All of this pushed hard for settlement rather than a trial and the risk of a jury verdict. □

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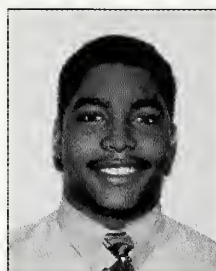
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Original Contribution

Cardiac Tamponade as the Initial Presentation of Bronchioloalveolar Cell Carcinoma

Joseph Hourany, MD; Ryland P. Byrd Jr., MD; Thomas M. Roy, MD

Introduction

A malignant pericardial effusion is found in approximately 20% of cancer patients at autopsy.³⁻⁵ Nevertheless, cardiac tamponade is rarely reported as the initial clinical manifestation of malignancy. When it does occur, primary bronchogenic neoplasms are present in the majority of the patients. These solid tumors have a tendency to metastasize to the mediastinal lymph nodes and to the pericardial lymphatic plexus. Bronchioloalveolar cell carcinoma (BCC) with cardiac tamponade as a presenting feature has been reported in only four patients.^{6,7} We present an additional patient who had a life-threatening pericardial effusion found to be due to this poorly understood pulmonary neoplasm.

Case Report

A 58-year-old white man was admitted to the hospital with severe and progressive dyspnea. He complained of a dry cough but denied fevers, chills, anorexia, and weight loss. His past medical history was unremarkable except for a 100 pack/year history of tobacco use. He had no known exposure to tuberculosis or environmental toxins, and no risk factors for human immunodeficiency virus (HIV).

He was afebrile, with a blood pressure of 118/76 mm Hg and a pulse rate of 116/min. Respirations were 26/min. His neck veins were distended in the upright position. Breath sounds were diminished in the right posterior lung base, and vo-

ABSTRACT

Bronchioloalveolar cell carcinoma (BCC) is a relatively uncommon form of bronchogenic cancer with an insidious onset and a variety of radiographic appearances. Although the World Health Organization currently classifies it as a subtype of adenocarcinoma,¹ many investigators view BCC as a distinct tumor with characteristic clinical features.² There are still uncertainties regarding its origin, as well as the significance of associated clinical findings such as cardiac tamponade.

cal and tactile fremitus were increased in the same area.

Admission laboratory data revealed a WBC count of 9,200/cu mm. His hematocrit, serum electrolytes, and thyroid function tests were all normal. Arterial blood gases obtained on breathing room air measured a pH of 7.43, Pco₂ 24 mm Hg, and Po₂ 55

mm Hg. His chest radiograph confirmed a globular heart and an infiltrate in his right upper, middle, and lower lobes (Fig. 1).

Shortly after admission, his blood pressure decreased to 84/40 mm Hg, with an increase in his pulse rate to 140/min, and a pulsus paradoxus of 18 mm Hg. His tachypnea worsened to 36/min. Hemodynamic monitoring showed the cardiac output decreased to 2 L/min, with an estimated cardiac index of 1.1 L/min/sq m. The systemic vascular resistance was calculated to be 2,279 dyne/sec/cu cm. Equalization of diastolic pressures was confirmed by a central venous pres-



Figure 1. Chest radiograph on admission shows a right-sided diffuse infiltrate with obliteration of the right hemidiaphragm.

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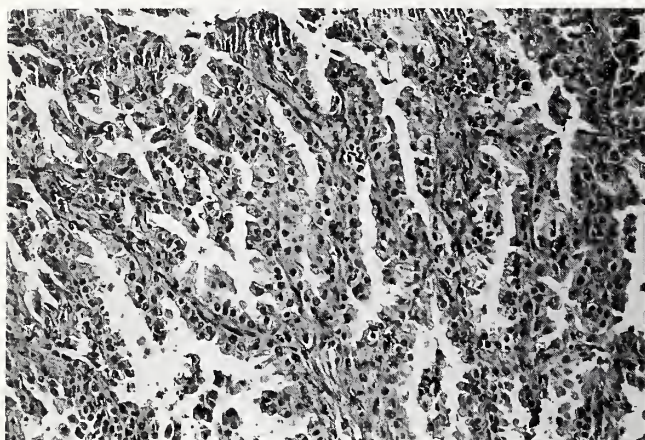


Figure 2. High-power H&E stained specimen from lung biopsy showing tall columnar cells with papillary growth with a preserved native septal architecture consistent with bronchioloalveolar cell carcinoma of the lung.

sure of 27 mm Hg, a pulmonary artery diastolic pressure of 26 mm Hg, and a pulmonary artery occlusion pressure of 26 mm Hg. His echocardiogram identified a large pericardial effusion and right ventricular diastolic collapse.

Through an emergency subxiphoid pericardial window 1,000 ml of bloody exudate were drained from the pericardial space. Initial cytologic examination of the fluid suggested, but could not confirm, a malignant neoplastic process. After fiberoptic bronchoscopy failed to yield a diagnosis, an open biopsy of the right upper lobe was done. Histologic examination demonstrated a well-differentiated BCC (Fig. 2). The patient died five days later of respiratory insufficiency.

Discussion

Only 78 cases of malignancy presenting itself as cardiac tamponade are reported in the medical literature.⁸ Primary lung cancers are responsible for the majority of these cases (Table 1), with bronchogenic adenocarcinoma responsible for 60% and squamous cell carcinoma 23%. Adenocarcinoma is usually peripheral in the pulmonary parenchyma. Its delayed recognition allows a greater opportunity for initial manifestation as cardiac tamponade. Squamous cell carcinoma, on the other hand, is typically recognized early due to symptoms caused by its central location and endobronchial origin.⁸

Adenocarcinoma, squamous cell, and large and small cell carcinomas of the lung cause pericardial effusions through lymphatic obstruction. These lung tumors metastasize to mediastinal lymph nodes. From these deposits, retrograde spread occurs to the epicardial lymphatic plexus.^{9,10}

Tumors that metastasize primarily by the hematogenous route or that rarely spread to mediastinal lymph nodes rarely cause tamponade (Table 1). This may partly explain why BCC is infrequently associated with pericardial effusion and tamponade. Although the route of pericardial lymphatic obstruction from BCC may be the same as that of adenocar-

TABLE 1
TUMOR TYPES PRESENTING AS CARDIAC TAMPONADE

Tumor Type	Number	Percentage
Primary lung carcinoma	48	61
Adenocarcinoma of unknown primary	8	10
Lymphoma/Leukemia	7	9
Gastrointestinal cancer	4	5
Mesothelioma	3	4
Ovarian carcinoma	2	2.5
Breast carcinoma	1	1
Other	6	7.5
TOTAL	79	100

cinoma, lymph node metastases occur in only 7.5% of patients with BCC.¹¹ In addition, there is one report of BCC presenting itself as cardiac tamponade diagnosed by pericardiocentesis in a patient without evidence of metastatic involvement of the mediastinal lymphatic system.⁶ This observation is consistent with the clinical experience that mediastinoscopy is less useful in patients with bronchioloalveolar cell lung cancer than in those with tumors of other cell types.¹²

Multiple epicardial and pericardial bronchioloalveolar cell tumor nodules have been documented at autopsy in patients with cardiac tamponade,⁷ which supports a hematogenous spread to the epicardium and pericardium by this tumor. This is intriguing, since the primary mechanism for spread of this tumor is the lepidic growth of malignant cells along alveolar walls and to other lobes via aerogenous spread.²

Immediate drainage of the pericardial fluid may be life-saving. Long-term management may require sclerosis of the pericardial space, pericardial fenestration, subxiphoid pericardiectomy, or balloon catheter pericardiectomy.⁸ While the prognosis for patients with cardiac tamponade due to malignancy is poor, prolonged survival with manageable morbidity is possible.⁸ □

References

1. Histological Typing of Lung Tumors. Geneva, World Health Organization, 1981, pp 1-36.
2. Jones DF, Chin RC Jr, Haponik EF: Bronchioloalveolar carcinoma. *Clin Pulm Med* 2:129-137, 1995.
3. Goudie RB: Secondary tumors of the heart and pericardium. *Br Heart J* 17:183-188, 1995.
4. Thurber DL, Edwards JE, Acher RWP: Secondary malignant tumors of the pericardium. *Circulation* 16:228-241, 1962.
5. Theologidis A: Neoplastic cardiac tamponade. *Semin Oncol* 5:181-192, 1978.
6. Benning TL, Finley JL, Silverman JF: Alveolar cell carcinoma presenting as malignant pericardial effusion: diagnosis by electron microscopy. *Ultrastructural Path* 16:303-306, 1992.
7. Brown SE, Harder HI, Brown AF: Bronchioloalveolar carcinoma presenting as pericardial effusion with tamponade. *West J Med* 124:500-502, 1976.
8. Muir KW, Rodger JC: Cardiac tamponade as the initial presentation of malignancy: is it as rare as previously supposed? *Postgrad Med J* 70:703-707, 1994.
9. Fraser RS, Viloria JB, Wang NS: Cardiac tamponade as a presentation of extra-cardiac malignancy. *Cancer* 45:1697-1704, 1980.
10. Tamura A, Matsubara O, Yoshimura N, et al: Cardiac metastasis of lung cancer. *Cancer* 70:437-442, 1992.
11. Daly RC, Trastek VF, Pairolero PC, et al: Bronchioalveolar carcinoma: factors affecting survival. *Ann Thorac Surg* 51:368-377, 1991.
12. Ferraro L, Solis R, Khan MA: Endobronchial spread of bronchoalveolar cell carcinoma. *Chest* 105:1627-1628, 1994.

Trauma Rounds

Repair of Penetrating Cardiac Injury Using Skin Staples

G. T. Chapman, MD and Scott B. Frame, MD

Introduction

Trauma centers across the country are seeing a rise in penetrating trauma. With this, the incidence of cardiac injury is also increasing. Patients who survive to reach the emergency department (ED) with penetrating injuries to the heart require rapid evaluation, resuscitation, and intervention if the patient is to survive. Cardiac tamponade must be treated expeditiously, and this often requires ED thoracotomy or rapid transport to the operating room (OR) for median sternotomy or thoracotomy.

In emergency surgical cases such as these, massive blood loss and exposure of surgical personnel to blood are characteristic. In an effort to minimize such exposure and hasten therapy in cardiac injuries, the use of skin staples has been described by the surgical department at the University of California in San Francisco and San Francisco General Hospital.¹ They chanced upon this technique in the animal laboratory when a left atrial cannula became accidentally dislodged during a research procedure. Appropriate suture material was not readily available, and the investigator used a standard skin stapler that was present in the laboratory to close the left atrium. They subsequently experimented with sheep in the laboratory and demonstrated that staples could be used successfully to control hemorrhage from lacerations in the atria, ventricles, and the proximal pulmonary artery. They have subsequently used the technique in the treatment of human patients with penetrating cardiac injuries with excellent success. This case report illustrates the use of the skin staple technique at the University of Tennessee Medical Center at Knoxville for the repair of a through-and-through stab wound to the heart.

Case Report

A 26-year-old man entered the ED at the University of Tennessee Medical Center at Knoxville with a history of a precordial stab wound. Initially the heart rate was 125/min, systolic blood pressure 51 mm Hg, and respiratory rate 22/min. The patient was awake but lethargic. He was immediately

intubated to secure the airway and high-flow intravenous access was obtained with peripheral lines and a left subclavian 8 french introducer. Volume resuscitation rapidly elevated the patient's blood pressure to the 90 to 100 mm Hg range. Examination showed a laceration at nipple level on the left sternal border. Though prehospital personnel reported a great deal of blood at the scene, there was no active hemorrhage from this stab wound in the ED. Central venous pressure at the time of insertion of the subclavian line was noted to be high. At this point the patient's blood pressure remained in the 90 to 100 mm Hg level and we thought the patient could be taken immediately to the OR for median sternotomy and cardiac exploration.

The patient was immediately transported to the OR for a standard median sternotomy. With retraction of the rib cage and examination of the anterior pericardium an obvious laceration on the anterior surface was visible, with clot readily apparent within the pericardial cavity. The pericardium was widely open from the diaphragm to the aortic root, and as the clot was evacuated, hemorrhage on the anterior surface of the heart was noted coming from the right ventricle. With relief of the tamponade, the patient suffered hemodynamic decompensation which was treated with vigorous fluid resuscitation. Finger tamponade on the right ventricular laceration was initially used to control hemorrhage, and a standard skin stapler (Ethicon 35W, Ethicon Corporation, Cincinnati, OH) was used to rapidly close this laceration.

Bright red blood continued to accumulate in the pericardial cavity during the course of the anterior laceration repair. Therefore after control of this hemorrhage, the heart was rotated medially and anteriorly to inspect the posterior surface, where an exit stab wound was producing rapid hemorrhage from the left ventricle. The skin stapler was again used, but this time could not completely control the hemorrhage. Teflon pledgeted Prolene sutures placed to buttress this repair achieved complete hemostasis.

During the attempts at repair of the posterior laceration, the patient did deteriorate to cardiac fibrillation, necessitating two attempts at electric defibrillation with internal paddles before normal cardiac rhythm was restored. With normal car-

From the Division of Trauma/Critical Care, University of Tennessee Medical Center, Knoxville.

diac rhythm and hemorrhage controlled, the patient rapidly regained hemodynamic stability with further fluid resuscitation. The heart was at this point continuously lavaged with warm saline solution to stabilize cardiac temperature. Also, the exit wound through the posterior pericardium was digitally probed, exiting into the left chest. Blood continued to well up through this pericardial laceration, necessitating exploration of the left hemithorax, which demonstrated some active hemorrhage from a laceration to the left lower lobe near the hilum. Hemorrhage was controlled with Davol lung clamps over the laceration and after a linear stapling to close this laceration and control hemorrhage, the left chest was liberally irrigated with normal saline. Complete hemostasis from all the patient's wounds having now been achieved, a 40 french left chest tube was placed and two 36 french mediastinal tubes were also positioned, a right-angle tube at the base of the pericardium and a straight tube over the anterior mediastinum. No attempts were made to close the pericardium, as the heart was edematous. The median sternotomy was closed in the usual fashion with sternal wires, and the patient was transported in stable condition to the trauma intensive care unit.

Postoperatively the patient remained hemodynamically stable. He progressed rapidly, regaining full consciousness within several hours, and was extubated approximately 24 hours after surgery. His chest tubes were all removed without complication by the fourth postoperative day. He had a holosystolic murmur, and an echocardiogram confirmed the traumatic ventricular septal defect. Since the septal defect was not hemodynamically significant, no further intervention was planned during this hospitalization. The patient did well without further complications, and was discharged to home on postoperative day 7, the status of the traumatic ventricular septal defect to be followed as an outpatient with repeat echocardiograms.

Discussion

The increase in penetrating cardiac injuries has paralleled the rise of violent crime in this country. Advances in pre-hospital care and resuscitation have allowed many of these patients to reach EDs with signs of life. The institution of effective trauma systems has seen these patients transported to trauma centers where rapid interventions can result in survival in what would previously have been considered lethal injuries. Trauma surgeons are now faced with more of these patients who require immediate surgical intervention, with an attendant increase in exposure to blood contamination. The cardiac staple technique greatly decreases the risk of blood contamination to the operating surgeons. It does not eliminate the chances of contamination during the performance of the thoracotomy or sternotomy, but it does eliminate the potential of a needle stick while suturing a cardiac wound on a beating heart.

The Department of Surgery at San Francisco General Hospital has published a report of a series of 28 patients successfully treated with cardiac stapling.¹ This paper was presented at the American Association for the Surgery of Trauma. During the discussions, several individuals stated that they have used this technique at their trauma centers, including the Washington Hospital Center and Ben Taub General Hospital in Houston. All have expressed satisfaction in their results using this technique.

A gun-type stapler with a long rotating head and wide (6 mm) staples is recommended, as it appears to provide the best results because visualization of the injury is better than with smaller stapler configurations and this enables precise placement of staples. The rotating head allows the easy approach to lacerations in multiple areas, including posterior lacerations and atrial lacerations, which may be inaccessible with other types of skin staplers. Standard staples may not allow adequate visualization for placement of the staples, and smaller staples tend to pull through the myocardium.

The question arises as to whether to leave staples in place or to use them only as temporary hemorrhage control. In the current case report, the choice was made to leave the staples in place, as excellent hemostasis had been obtained and close inspection of the heart demonstrated no tearing of the myocardium at the staples. However, some authors believe that stapled repairs should be buttressed with pledgeted sutures, followed by removal of the staples.¹ Patients followed for up to two to three years with staples in place have failed to demonstrate any adverse effects. The San Francisco General Hospital group have tended more recently to leave staples in place and not attempt to remove them (verbal communication). We also believe that this is a safe course of action as long as staples have been appropriately placed and adequately controlled hemorrhage.

Successful management of cardiac injuries depends upon rapid transport of the patient to an appropriate facility, prompt resuscitation, high index of suspicion with early recognition of the injury, and immediate definitive surgical management with resumption of normal cardiac activity.²⁻⁶ Stapling allows rapid control of hemorrhage in most cases and may allow for more effective resuscitation and reversal of shock. Both of these should result in improved survival.

Multiple chamber wounds are encountered in as many as 10% to 15% of cases of penetrating cardiac trauma, and present a distinct challenge to the trauma surgeon.^{7,8} This report demonstrates this exact type of injury. We believe that the ease of hemorrhage control and the rapidity with which it was obtained had a direct influence on this patient's excellent outcome. He suffered no neurologic deficit, and progressed to a rapid and satisfactory recovery. Rapid control of hemorrhage from the posterior cardiac wound in the left ventricle was definitely accomplished much more rapidly than

had attempts initially been made with sutures. These wounds are very awkward to approach, and the use of staples allowed a minimal length of time when the heart had to be rotated out of its normal anatomic position. Such rotation compromises venous return and cardiac function, and minimizing the time when the heart is rotated medially and anteriorly improves the patient's hemodynamic status.

In the current era of hepatitis, AIDS, and other blood-borne pathogens, minimizing potentially high-risk activities is advantageous to personnel caring for trauma patients. Suture cardiorrhaphy performed in the ED or in the OR is a high-risk activity, given the patient population normally involved and the suture technique required. The use of the skin stapler to effectively control hemorrhage from cardiac wounds minimizes this potential risk.

Summary

Cardiac stapling is a highly effective technique in the management of hemorrhage from penetrating cardiac injuries. It may allow the salvage of patients with multiple cardiac lacerations who would not otherwise survive following standard suture techniques for repair. Cardiac stapling is prob-

ably not indicated in complex injury cases such as those from gunshot, and the trauma surgeon must use judgment in applying the staple technique, though its use for cardiorrhaphy in the ED and the OR will minimize the risk of contamination of personnel from a needle stick from the repair portion of the surgical procedure. Staplers are readily available, easy to use and safe to surgical personnel, and they provide rapid and effective hemostasis. □

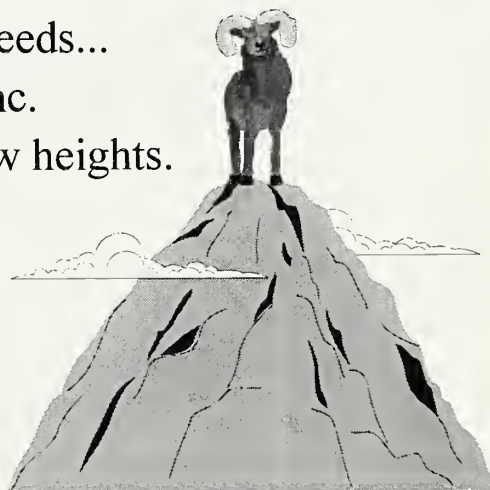
References

1. Macho JR, Markison RE, Schechter WP: Cardiac stapling in the management of penetrating injuries of the heart: rapid control of hemorrhage and decreased risk of personal contamination. *J Trauma* 34:711, 1993.
2. Blatchford JW III, Anderson RW: The evolution of the management of penetrating wounds of the heart. *Ann Surg* 202:615, 1985.
3. Baxter BT, Moore EE, Moore JB, et al: Emergency department thoracotomy following injury: critical determinants for patient salvage. *World J Surg* 12:671, 1988.
4. Buchman TG, Phillips J, Menker JB: Recognition, resuscitation and management of patients with penetrating cardiac injuries. *Surg Gynecol Obstet* 174:205, 1992.
5. Demetriades D, Rabinowitz B, Sofianos C: Emergency room thoracotomy for stab wounds to the chest and neck. *J Trauma* 27:483, 1987.
6. Trinkle JK: Penetrating heart wounds: difficulty in evaluation. *Ann Thorac Surg* 38:181, 1984.
7. Knott-Craig CJ, Dalton RP, Rossouw GJ, et al: Penetrating cardiac trauma: management strategy based on 129 surgical emergencies over two years. *Ann Thorac Surg* 53:1006, 1992.
8. Kulshrestha P, Das B, Iyer KS, et al: Cardiac injuries—a clinical and autopsy profile. *J Trauma* 30:203, 1990.

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Vanderbilt Morning Report

A Diabetic Man With Left Shoulder Pain

Case Report

A 65-year-old man with adult onset diabetes mellitus, hypertension, and cerebrovascular disease presented himself to the Nashville VA Medical Center emergency department with a chief complaint of progressively severe left shoulder pain for 12 hours. The patient denied any recent trauma or injury. He felt well until two days before admission, when he developed nausea and constipation, and twice vomited clear liquid. He denied chest or abdominal discomfort, dyspnea, fever, or chills. While being evaluated, he began to have pain in his right thigh. His medications included NPH insulin, enteric coated aspirin, diltiazem, hydralazine, furosemide, fluvastatin, and amitriptyline. He had an allergy to penicillin that causes hives.

Physical examination revealed an alert, obese man with a temperature of 98.0°F, blood pressure 160/92 mm Hg, heart rate 94/min, and respiratory rate 18/min. He was diaphoretic, his lungs were clear to auscultation, and his heart sounds were regular, without murmur or rub. There was no lymphadenopathy. Examination of the abdomen, left arm, and right leg was unremarkable. Laboratory evaluation revealed a WBC count of 18,000/cu mm, with a differential of 92% neutrophils, 4% lymphocytes, and 4% monocytes. The hematocrit was 39%. Chemistries revealed a sodium of 133 mEq/L, chloride 103 mEq/L, bicarbonate 19 mEq/L, BUN 31 mg/dl, creatinine 2.5 mg/dl, glucose 378 mg/dl, and CPK 650 IU/L. Electrocardiographic findings included sinus tachycardia with a rate of 100/min and no acute ST-segment changes or Q-waves. He was admitted to the intensive care unit with a diagnosis of unstable angina.

Over the next eight hours, he developed a fever of 101°F and his left arm pain worsened. Initial chest x-ray revealed a small amount of subcutaneous emphysema in the left axilla, which on subsequent radiograph showed rapid progression to involve the left arm and chest wall (Fig. 1). He was treated with intravenous vancomycin, metronidazole, clindamycin and ceftazidime, and emergency surgical consultation was obtained. The patient developed bullous lesions over the posterior deltoid, associated with crepitance over the left axilla

and chest wall, as well as over the right quadriceps region. In conjunction with the patient's family, his physicians decided to provide supportive care only in light of the extent of his disease. He died 14 hours after his initial presentation, and postmortem examination was declined. Blood cultures later grew *Clostridium septicum*.

Discussion

C. septicum is a gram-positive, spore-forming, anaerobic bacillus that can flourish in ischemic or necrotic tissue. Myonecrosis, or "gas gangrene," due to clostridial species, has been well recognized as a complication of trauma in battles and motor vehicle accidents, as well as in abdominal and pelvic surgical wounds. Nontraumatic clostridial infection is rare. Three patterns of this entity have been described: visceral anaerobic cellulitis, visceral cellulitis with spread to adjacent muscle, and myonecrosis at a site distant to the primary infection.¹ The last form is least common, but usually presents a fulminant course and portends a grim prognosis.

Early recognition and a high index of suspicion for the diagnosis are essential for successful management. Jendrzewski and colleagues¹ outlined the signs and symptoms usually seen in this syndrome. Clostridial myonecrosis



Figure 1. Extensive subcutaneous emphysema is seen in the left axilla and chest wall about 12 hours after initial presentation.

Presented by Francis J. Caprio, MD, primary care chief medical resident, VA Medical Center, Nashville.

often presents with a sense of heaviness in the affected area and pain that is out of proportion to physical findings. Rapid development of progressive, brawny edema is typically followed by formation of hemorrhagic bullae of the overlying skin. Crepitance may be minimal early in the course, and subcutaneous gas can often be identified on roentgenogram prior to its development on physical examination. Low-grade fever and a heart rate faster than expected for the corresponding body temperature may be seen. Mental clarity is typically preserved, though patients are often apprehensive. WBC count may or may not be elevated, and there may be laboratory evidence of hemolysis. Gram stain of fluid aspirated from bullae or affected tissue typically reveals large gram-positive rods with few inflammatory cells. Definitive diagnosis is usually made from cultures obtained from blood or from tissue obtained during debridement.

Nontraumatic clostridial infections are often seen in immunocompromised hosts in association with breakdown of mucosal integrity in the bowel, particularly in the setting of leukemia, colorectal cancer, necrotizing colitis, diabetes, or cyclic granulocytopenia. Kornbluth et al² reviewed the 162 cases of this syndrome reported in the English language literature between 1945 and 1987, and found that 131 cases (81%) occurred in patients with previously diagnosed or occult malignancy. Sixty-five cases (40%) were associated with hematologic malignancy, while 55 cases (34%) occurred in patients with colorectal carcinoma. Of the latter group, lesions were situated in the cecum in almost half of the cases.

Diabetes mellitus was a factor in 19% of patients, and occult malignancies were most often discovered in these patients.

Immediate initiation of antibiotic therapy and emergency surgical debridement of all areas of necrosis are essential, as mortality is near 100% in untreated cases. Intravenous penicillin at dosages of at least 10 million units per day has been recommended as the drug of choice.² In patients with penicillin allergy, metronidazole or clindamycin is a suitable alternative. Since gas gangrene and myonecrosis are not specific for clostridial species, initial antibiotics should also cover streptococcus, staphylococcus, enterococcus, gram-negative organisms, and bacteroides. Use of hyperbaric oxygen as adjunctive therapy may improve survival, though controlled randomized trials of efficacy in humans are lacking.³ *C. septicum* produces several exotoxins that determine virulence, including the lecithinase alpha toxin, but antitoxin administration has not proven to be clinically useful.³ Survival rate for nontraumatic clostridial infections is 35%, although the subset of patients with distant foci of myonecrosis fare worse, with survival rates close to 20%.² Survivors of *C. septicum* infection should be investigated for occult colonic malignancy. □

References

1. Jendrzejewski JW, Jones SR, Newcombe RL, et al: Nontraumatic clostridial myonecrosis. *Am J Med* 65:542-546, 1978.
2. Kornbluth AA, Danzig JB, Bernstein LH: *Clostridium septicum* infection and associated malignancy. *Medicine* 68:30-37, 1989.
3. Ukwu HN, Gregory DW: *Clostridium septicum* myonecrosis and sepsis in the absence of trauma. *South Med J* 84:1128-1130, 1991.

HELP FOR IMPAIRED PHYSICIANS

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Department of Health Report

Postexposure Immunoprophylaxis And Chemoprophylaxis for Communicable Diseases

William L. Moore, MD

Treatment of disease, whether caused by illness or injury, accounts for by far the greatest proportion of effort and expense in health care delivery. Prevention of disease is a highly desirable and tremendously cost-effective enterprise. Prophylaxis following exposure to a variety of communicable diseases is a well-established principle that promises to grow in significance as emerging technology and emerging diseases increasingly demand our attention.

Immunoprophylactic agents include immune serum globulin (ISG), hepatitis B immune globulin (HBIG), varicella-zoster immune globulin (VZIG), and human rabies immune globulin (HRIG). Other hyperimmune globulin preparations can be prepared from pooled plasma of individuals with high antibody levels to a specific agent such as mumps or measles.

Hepatitis A occurs throughout the United States both sporadically and in periodic outbreaks. The administration of ISG, derived from pooled plasma, has been shown to prevent infection or reduce severity of disease in individuals who have had a significant exposure to hepatitis A virus.

Although risk should be assessed in each situation, household and close family contacts of an infectious case, close playmates, physically intimate contacts, and persons such as day care attendants (especially those exposed to infected diapered infants) are candidates for hepatitis A immune prophylaxis. Since the incubation period for hepatitis A can be as short as two weeks, immune globulin, in a dose of 0.02 ml/kg body weight, should be administered intramuscularly not later than two weeks after exposure.

Unfortunately, while this is of established benefit in protecting individuals, it is of no value in terminating community outbreaks of the disease. For individuals who risk re-

peated exposure, short-term protection with immune globulin along with active immunization with hepatitis A vaccine is rapidly gaining favor as the proper approach.

A number of hepatitis A outbreaks are occurring throughout the United States at present. The largest is in the state of Oregon. The Memphis/Shelby County area has had nearly 2,000 cases reported since July 1994.

In Tennessee alone, nearly 20,000 doses of ISG have been administered over the last two years. In addition, large numbers of deploying U.S. services members have been given preexposure ISG. As a consequence, there is a national shortage of ISG and its use should strictly follow judicious guidelines.

Similarly, persons with known exposure to hepatitis B virus through blood or sexual contact, or newborns of HBsAg-positive mothers, benefit from administration of HBIG. It is important to administer HBIG as soon as possible after delivery or other exposure. These infants should receive 0.5 ml of HBIG intramuscularly within 12 hours of birth along with the initial dose of hepatitis B vaccine. For susceptible adults following exposure to HBsAg-positive blood or body fluids, a dose of 0.06 ml/kg body weight up to 5 ml should be given intramuscularly as soon as possible. A comparable dose given within 14 days of sexual exposure to a person infected with acute or chronic active hepatitis B is currently recommended. Any individual who is repeatedly at risk should be actively immunized with hepatitis B vaccine.

Although human rabies is rare in the United States, it is invariably fatal. The effectiveness of postexposure immunoprophylaxis is well established, but development of rabies after adequate postexposure prophylaxis is occasionally reported. The risk of exposure to rabies must be carefully assessed in each case.

The fear evoked by the threat of rabies often leads patients to demand inappropriate prophylaxis and physicians often relent in the face of those demands. Although health

From the Tennessee Department of Health, Nashville. Dr. Moore is the Tennessee State Epidemiologist and Director of Communicable and Environmental Disease Services at TDH.

departments throughout Tennessee do not maintain stocks of rabies immune globulin and rabies vaccine, consultation is available at local, regional, and state levels to assist in determining the appropriateness of its use in a given case. Recent human cases have been associated with exposure to bats even when no bite can be found. For cases of bat exposure, more liberal use of postexposure passive and active immunity should be considered.

All bite wounds must be cleansed immediately and thoroughly with soap or detergent and flushed with ample volumes of water. This has been shown experimentally to be a very important step in preventing rabies. HRIG at 20 IU/kg body weight must then be administered as soon as possible, with half the dose at the wound site and the remainder at a remote intramuscular site. Active immunization should be initiated simultaneously but given in a different site than the HRIG. Rabies immune globulin is not recommended for individuals who have previously received preexposure or postexposure prophylaxis.

The basic principles of postexposure immunoprophylaxis are represented in the examples above. First, assess the risk of exposure, administer the specific immune globulin at the earliest possible time, and initiate active immunization.

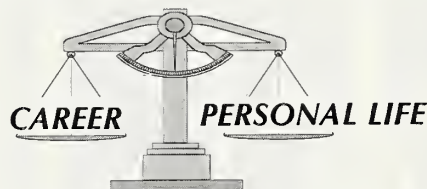
Chemoprophylaxis of certain infectious diseases is of established efficacy in preventing secondary cases or community outbreaks. During World War II, outbreaks of meningococcal disease were prevented by administration of sulfonamides to close contacts of cases, especially in closed environments such as military barracks. Although still effective against known susceptible strains, resistance to sulfonamides has become widespread. Rifampin, ceftriaxone, or ciprofloxacin are currently recommended. Prophylaxis should be administered only to household and other intimate contacts, based on a careful assessment of the likelihood of exposure. It is not necessary to provide prophylaxis to entire classrooms or other casual contacts. Rifampin, given at 600 mg twice daily for two days to adults, 10 mg/kg for infants and children over one month of age, and 5 mg/kg for those less than one month of age, is currently the preferred prophylactic program. Active immunization with meningococcal vaccine may be indicated if clusters of cases occur in relatively close proximity.

As infection with the human immunodeficiency virus (HIV) continues to spread, health care workers are increasingly at risk of exposure by needle sticks and other sharp instruments contaminated with blood. The overall rate of infection following such exposure in health care workers with no other risks is about 3 per 1,000 exposures. Stratifications of risk suggest that the volume of blood and depth of exposure are highly correlated with infection, although transmission following superficial exposure to mucous membrane has been observed. Recent evidence suggests that short-term ad-

ministration of zidovudine (ZDV) following such exposure may be protective, but failures of prophylaxis are well documented. The FDA has not approved the drug for postexposure prophylaxis, and recommendations for its use have been equivocal. Based upon the findings reported in the December 22, 1995 *Morbidity and Mortality Weekly Report*, it seems likely that ZDV should be used in doses of 1,000 mg/day for three to four weeks unless further studies of efficacy toxicity indicate otherwise. With the availability of protease inhibitors, an assessment of combined-drug postexposure prophylaxis, will be evaluated. Given the small number of cases, efficacy will be difficult to determine.

In summary, prevention of disease is a laudable goal and postexposure prophylaxis is of proven efficacy and cost-effectiveness in preventing several communicable diseases. Established principles must be followed and sound judgment applied in selecting individuals for postexposure prophylactic regimens. □

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TMA Alliance Report

Yes, We Can!

The Tennessee Medical Association Alliance has a mission, and that is to assist in programs of the TMA that improve the health and quality of life of all people. The Alliance promotes health education, encourages participation of volunteers in activities that meet health needs, and supports health-related charitable endeavors. Each member of the Alliance has an opportunity, a privilege, and an obligation to serve our fellow man.

With a motto of "Yes, we can!" the Alliance begins a new year with emphasis on four main areas. We *can* continue our strong commitment to and leadership for fund raising for AMA-ERF (American Medical Association Education and Research Foundation). The Tennessee Alliance traditionally leads the nation in fund raising for AMA-ERF. In the 1995-1996 year the Alliance raised approximately \$180,000 and is still counting. This is of vital importance to the education of future physicians. We *can* make a contribution to the good health of all Tennesseans with the many local county health projects. TMAA supports the AMAA SAVE (Stop America's Violence Everywhere) program. Our goal this year is to have each county alliance mark SAVE Today, October 9, 1996, in some way. We *can* be a voice for the medical community on legislative issues, and make sure we are heard—always with the goal of the best interest of the health and well-being of the patient.

We *can* increase our membership. This is of vital importance. Membership is a major focus this year. The role of every member is important, whether supporting, contributing or both. The valuable work of the Alliance should appeal to spouses of all physicians. We need to spread the word! TMA reports a membership of over 6,000 members. The Alliance has slightly fewer than 2,000. There is great potential for an increase in membership. There is the possibility of establishing some new county alliances. The Alliance welcomes and encourages help from the TMA in recruiting members.

We Tennesseans know all about volunteering. Working with the TMA, the Alliance can make a difference for the good health of our fellow man. *Yes, We Can!*

Annelle Bond
TMAA President

Personal News

Susan T. Andrews, M.D., president of the Rutherford County-Stones River Academy of Medicine, and *David L. Johnson, M.D.*, secretary of the Academy, have been elected to the Rutherford County School Board. This is a special honor because this is the first year members have been elected to the board; up to this point the board has been appointed.

Patrick Maxwell, M.D., Nashville, has been named one of the honorary chairpersons of Operations Smile, a non-for-profit organization devoted to providing corrective surgery and advocacy for underserved children in Tennessee and Kentucky suffering from facial deformities.

In Memoriam

Sam Young Garrett, age 77. Died May 2, 1996. Graduate of Harvard Medical School. Member of Nashville Academy of Medicine.

V. H. Griffin, age 90. Died May 16, 1996. Graduate of Vanderbilt University School of Medicine. Member of Montgomery County Medical Society.

James T. Hayes Sr., age 94. Died April 28, 1996. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Matthew W. Wood Sr., age 71. Died May 3, 1996. Graduate of University of Tennessee College of Medicine. Member of Memphis-Shelby County Medical Society.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

Mary E. Carter, MD, Chattanooga
John R. Collins, MD, Chattanooga
Larry R. Debarge, MD, Chattanooga
Frank R. Eldridge, MD, Hixson
Jitendra G. Gandhi, MD, Chattanooga
Elaine W. Hatch, MD, Hixson
Kenneth H. Hayman Jr., MD, Hixson
Gordon A. Herrald, MD, Chattanooga
Bessie A. Ingram-Nunally, MD, Chattanooga
Oliver W. Jenkins Jr., MD, Chattanooga
Lizbeth A. Kennedy, MD, Chattanooga
Marian G. May, MD, Hixson
Steven L. May, MD, Hixson
Becky S. McMahan, MD, Hixson
David L. Neall, MD, Hixson
James T. Nunally Jr., MD, Chattanooga
Richard R. Pesce, MD, Chattanooga
Richard E. Poehlein, MD, Hixson
Bryan Richardson, MD, Chattanooga
Jane L. Rohrer, MD, Chattanooga
Ann H. Rybolt, MD, Chattanooga

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE

Jeff S. Zabel, MD, Jackson

DICKSON COUNTY MEDICAL SOCIETY

T. Edwin Cook, MD, Dickson
Anthony G. Zimmermann, MD, Dickson

KNOXVILLE ACADEMY OF MEDICINE

Robert E. McDonald Jr., MD, Knoxville

LAKEWAY MEDICAL SOCIETY

Dana P. Edwards, MD, Morristown

Stephen P. Graham, MD, Morristown
Elizabeth A. Jones, MD, Morristown
Charles E. Leonard, MD, Jefferson City
Robert A. Sarlo, MD, Morristown
Harry A. Zain, MD, Morristown

MAURY COUNTY MEDICAL SOCIETY

Jeffrey J. Gleason, MD, Columbia

MEMPHIS-SHELBY COUNTY MEDICAL SOCIETY

Maroun T. Dick, MD, Memphis
Mark C. Dixon, MD, Memphis
John E. Goddard, MD, Germantown
William T. Herring, MD, Memphis
Garnett A. Murphy, MD, Germantown
Michael D. Neel, MD, Memphis
Seth L. Yoser, MD, Memphis

NASHVILLE ACADEMY OF MEDICINE

Steven P. Key, MD, Nashville
Kimberly A. Klippenstein, MD, Nashville
Jeffrey S. Lodge, MD, Nashville
Alexander G. Nein, MD, Nashville
Andrew R. Sager, MD, Nashville
John T. Shaw, MD, Nashville
Joseph A. Wieck, MD, Nashville
Michael D. Zanolli, MD, Nashville

NORTHWEST TENNESSEE ACADEMY OF MEDICINE

Daniel P. Green Jr., MD, Newbern
Mohan P. Rao, MD, Dyersburg

PUTNAM COUNTY MEDICAL SOCIETY

Evangelito C. Garingan, MD, Chattanooga

ROANE-ANDERSON COUNTY MEDICAL SOCIETY

Camilla C. Bennett, MD, Oak Ridge

ROBERTSON COUNTY MEDICAL SOCIETY

Willie V. Melvin, MD, Springfield

SULLIVAN COUNTY MEDICAL SOCIETY

John B. Raff, MD, Kingsport
James M. Turnbull, MD, Kingsport

WILLIAMSON COUNTY MEDICAL SOCIETY

John R. Thompson, MD, Nolensville

WILSON COUNTY MEDICAL SOCIETY

Gary G. Gallant, MD, Lebanon

Board of Medical Examiners

Minutes - April, 1996

Name: Richard Bell, MD (Murfreesboro)

Violation: Personal misuse of drugs; unprofessional, dishonorable, or unethical conduct; dispensing, prescribing, or distributing a controlled substance in violation of law.

Action: Per agreed order, license placed on probation for one year; suspension of DEA certificate, may request permission to apply for reinstatement in one year; must notify the Board upon

reissuance of DEA certificate and submit copies of all required controlled substance logs quarterly for one year; assessed civil penalty of \$500; must maintain advocacy of the Impaired Physician Program.

Name: Rhonda Brennan, MD (Nashville)

Violation: Unprofessional, dishonorable, or unethical conduct; violation of a criminal statute; dispensing, prescribing, or distributing a controlled substance not in the course of professional practice or not in good faith to relieve pain and suffering, or not to cure an ailment, physical infirmity, or disease; engaging in the practice of medicine when mentally or physically unable to do so safely.

Action: Per agreed order, summary suspension lifted; license placed on probation for five years; practice restricted for one year to one specific practice location approved by the Board; practice restricted to specialty of psychiatry; must be supervised by a licensed psychiatrist or addictionologist for one year; must have patient files reviewed by supervisor; must maintain the advocacy of the Impaired Physician Program during probation period; must show proof that all pending criminal matters against her are resolved prior to engaging in the practice of medicine; must maintain recommended therapy; must strictly observe all federal regulations regarding storage, logging, and issuance of controlled substances if/when DEA registration is restored; must complete additional continuing medical education; must notify any employers or facilities where she may obtain privileges of disciplinary action; may not apply for reinstatement of DEA for one year; must notify the Board of any application for licensure in another state; may not seek modification of agreed order for two years.

Name: Freeman Clark, MD (Memphis)

Violation: Disciplinary actions in other states.

Action: License placed on probation for two years; must maintain contract with the Impaired Physician Program (IPP); must limit practice outside his residency to a schedule satisfactory to IPP; must continue psychiatric treatment; must complete 150 hours of community service; must notify hospitals where practice privileges have been granted; assessed a civil penalty of \$100.

Name: George Knox III, MD (Nashville)

Violation: Overprescribing.

Action: Per agreed order, license placed on probation for one year; must complete course on overprescribing; assessed civil penalty of \$500.

Name: Gita Mishra, MD (Nashville)

Violation: Failure to meet CLIA regulations.

Action: Per agreed order, must agree to unannounced inspections of her office by the Department of Health during the next six months and abide by any recommendations made for repair.

Name: Anup K. Satpathy, MD (McKenzie)

Violation: Conviction of a DUI and failure to disclose conviction on license renewal application.

Action: Per agreed order, license placed on probation for one year; must appear personally before Board at the end of probationary period; must notify any health care facility or agency where he applies for or obtains privileges; assessed civil penalty of \$1,000.

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during April, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

David G. Alfredson, MD, Belfast
Robert F. Baker, MD, Sparta
Arlene J. Donowitz, MD, Chattanooga
Arthur C. Fleischer, MD, Nashville
Carl R. Hampf, MD, Nashville
W. Powell Hutcherson, MD, Chattanooga
Nat E. Hyder Jr., MD, Johnson City
Eugene R. Kidwell, MD, Kingsport
Michael O. Koch, MD, Nashville
Rodger P. Lewis, MD, Union City
Bernardino D. Marcelo, MD, Rogersville
Josephina Q. Marcelo, MD, Rogersville
Warren T. Norman, MD, Fayetteville
Stewart N. Perlman, MD, Nashville
Rodney A. Poling, MD, Columbia
James S. Powers, MD, Nashville
Gregory R. Weaver, MD, Nashville
Michael J. Winsor, MD, Kingsport

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

Special Conferences/Seminars

Detailed brochures for the following courses are available. In some cases, registration numbers are limited.

July 15-19 Contemporary Clinical Neurology—Hilton Head Isl., S.C.
Aug. 8-9 Endoscopic Sinus Surgery and Revision Surgery Workshop
Aug. 15-16 1st Clinical Oncology Symposium
Sept. 25-28 Pulmonary/Critical Care Medicine—Destin, Fla.
Oct. 18-19 Laryngeal Video Endostroboscopy Workshop
Nov. 13-16 2nd Neonatology Symposium—Asheville, N.C.
Dec. 6-7 22nd High Risk Obstetrics Seminar

For information contact Division of CME, Vanderbilt University School of Medicine, D-821 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

Continuing Education Schedule

Memphis

July 22-27 Contemporary Issues in Obstetrics and Gynecology—Destin, Fla.
Aug. 17-22 Pharmacology of Thermoregulation
Sept. 19-20 28th Conference on the Mother, Fetus, and Newborn

Knoxville

Sept. 6 Hormone Replacement Conference
Sept. 15-17 Internal Medicine Conference—Gatlinburg
Oct. 11-12 Genetics Conference
Oct. 14-16 18th Obstetric Office Ultrasound Workshop
Oct. 28-30 16th Smoky Mountains Ob/Gyn Seminar—Gatlinburg
Nov. 15-16 New Concepts in the Treatment of Cardiac Disorders
Nov. 18-19 Pediatric Trauma Conference
Dec. 3-5 Perinatal Update '96—Gatlinburg

For information contact Mrs. Jean Taylor Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163, Tel. (901) 448-5547.

Meharry Medical College

Extended Continuing Education Program

Arrangements have been made with many services and departments in the medical school to allow practicing physicians to participate in the service's activities for a period of one day to one week. This program provides an opportunity for physicians to study in depth for a specified period. The schedule of activities is individualized in response to the physician's request by the participating department. The experience includes conferences, ward rounds, audiovisual materials and contact with patients, residents and faculty.

Fee: \$75 per day or \$275 per five-day week of educational experience including lunch and parking at Meharry Medical College. **Credit:** AMA Category 1 of the Physician's Recognition Award, AAFP, and Continuing Education Units from Meharry Medical College. **Application:** For information contact Henry A. Moses, Ph.D., Director of Continuing Education, Meharry Medical College, 1005 D.B. Todd Blvd., Nashville, TN 37208, Tel. (615) 327-6235.

St. Thomas Hospital—Nashville

Continuing Education Schedule

Sept. 21 Contemporary Topics in Surgical Pathology X: A Pot Pourri of Surgical Pathology

For information contact Registration Secretary, St. Thomas Hospital, (615) 222-2007.

Highlights of the TMA Board of Trustees Meeting

April 10 and 14, 1996

The following is a summary of the major actions taken by the Board of Trustees of the Tennessee Medical Association at its regular second quarter meeting in Knoxville, April 10 and 14, 1996. The Board:

Tennessee Medical Foundation

Received the annual report from Dr. David Dodd, Medical Director of the Tennessee Medical Foundation, on the Impaired Physician Program.

TMA Subsidiary Reports

Received annual reports from TMA Physician Services, Inc. and The TMA Association Insurance Agency, Inc.

TMA Strategic Plan

Received a report from Dr. Richard Pearson on the progress of the TMA Strategic Plan.

Board of Medical Examiners

Agreed to submit the following names for consideration of appointment to the Board of Medical Examiners (representing East Tennessee): Drs. David O'Neal, Chattanooga; Ralph McGraw, Chattanooga; and Hays Mitchell, McDonald.

Agreed to submit the following names for consideration of appointment to the Board of Medical Examiners (representing Middle Tennessee): Drs. Daniel L. Starnes, Nashville (for reappointment); Thurman L. Pedigo, Nashville; and Subhi D. Ali, Waverly.

Emergency Medical Services Board

Agreed to submit the following names for consideration of appointment to the Emergency Medical Services Board: Drs. Donald E. Barker, Chattanooga; Marshall J. Stout, Kingsport; and Sullivan Smith, Cookeville.

Medical Laboratory Board

Agreed to submit the following names for consideration of appointment to the Medical Laboratory Board: Drs. Richard E. McLendon, Memphis; Donald Stockstill, Memphis; William D. Burton, Memphis.

AMA Alliance President-Elect

Agreed to financially assist in hosting a reception honoring Mrs. Johnnie Amonette, AMA Alliance's president-elect, at the AMA meeting in June 1997.

Resolutions and Bylaw Amendments

Reviewed all resolutions and Bylaw amendments to be submitted to the House of Delegates and took a position on each.

1995 Audit

Approved the 1995 audit of the Tennessee Medical Association as submitted by TMA's certified public accountants, Bellenfant and Miles, P.C.

Quarterly Reports

Received quarterly reports from the following: State Volunteer Mutual Insurance Company (SVMIC), Independent Medicine's Political Action Committee of Tennessee (IMPACT), Tennessee Medical Foundation, Tennessee Delegation to the AMA, and the TMA Alliance.

Retiring Board Members

Recognized retiring members of the Board of Trustees: Drs. Virgil H. Crowder Jr.; Thurman L. Pedigo; Charles T. Womack; and Phillip E. Wright II, and presented an engraved plaque to each retiring member.

BHO Meeting with Commissioner Corker

Agreed to meet with state Finance and Administration Commissioner Corker concerning the plan to include mental health services in the TennCare program.

Board of Trustees Officers

Elected Drs. Michael A. McAdoo, Milan, as chairman of the Board and William B. Harwell, Jr., Nashville, as vice-chairman.

Association Officers

Elected Dr. James Chris Fleming, Memphis, as secretary/treasurer of the Association, and Mr. Donald H. Alexander as assistant secretary/treasurer.

Medical Specialty Officers

Appointed members of the Board to serve as liaisons to the medical specialty organizations.

TMA Impaired Physician Loan Fund Inc.

Agreed to appoint the following physicians to serve a one-year term on the TMA Impaired Physician Loan Fund, Inc. Board of Directors: Drs. William C. Anderson, Nashville; Luthur A. Beazley Jr., Nashville; James Chris Fleming, Memphis; Murray W. Smith, Nashville; Charles B. Thorne, Nashville. □

TMA Leadership 1996-1997

OFFICERS OF THE ASSOCIATION

President	Richard M. Pearson, MD, Memphis
President-Elect	R. Benton Adkins, MD, Nashville
Vice-President (East)	John J. Ingram III, MD, Maryville
Vice-President (Middle)	Subhi D. Ali, MD, Waverly
Vice-President (West)	Neal S. Beckford, MD, Memphis
Secretary-Treasurer	James Chris Fleming, MD, Memphis
Speaker—House of Delegates	Robert D. Kirkpatrick, MD, Memphis
Vice-Speaker—House of Delegates	Sam J. Williams III, MD, Chattanooga

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Richard M. Pearson, MD	Memphis
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Second District	John E. DePersio, MD, Knoxville
Third District	Donna K. Hobgood, MD, Chattanooga
Fourth District	A. Austin Jones, MD, Livingston
Fifth District	Theresa T. Morrison, MD, Fayetteville
Sixth District	H. Victor Braren, MD, Nashville, <i>Chairman</i>

TENNESSEE MEDICAL ASSOCIATION STUDENT EDUCATION FUND

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Ronald L. Pack, MD	Knoxville
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William L. Hickerson, MD	Memphis
Michael A. McAdoo, MD (Ex-Officio)	Milan
John H. Burkhart, MD (Consultant)	Knoxville

HOUSE OF DELEGATES SECTIONS

Young Physician Section

Chairman	David S. Goldberg, MD, Nashville
Chairman-Elect	Steven G. Flatt, MD, Cookeville
Secretary	Tara L. Sturdivant, MD, Newport
AMA Delegate	John W. Hale, MD, Union City
AMA Delegate	Steven G. Flatt, MD, Cookeville
AMA Alt. Delegate	Mark David Patterson, MD, Greeneville
AMA Alt. Delegate	Tara L. Sturdivant, MD, Knoxville
TMA East Tenn. Delegate	Tara L. Sturdivant, MD, Knoxville
TMA East Tenn. Alt. Delegate	(To be elected)
TMA Middle Tenn. Delegate	David S. Goldberg, MD, Nashville
TMA Middle Tenn. Alt. Delegate	(To be elected)
TMA West Tenn. Delegate	John W. Hale, MD, Union City
TMA West Tenn. Alt. Delegate	(To be elected)

Seventh District	Malcolm A. Cox, MD, Pulaski
Eighth District	James D. King, MD, Selmer, <i>Secretary</i>
Ninth District	Kenneth R. Maloney, MD, Dyersburg
Tenth District	Patrick J. Murphy, MD, Memphis

DELEGATES TO THE AMA

Charles Ed Allen, MD	Johnson City
Robert E. Bowers, MD	Chattanooga
Allen S. Edmonson, MD	Memphis
James Chris Fleming, MD	Memphis
Hugh Francis Jr., MD	Memphis
Francis W. Gluck Jr., MD	Nashville
Thurman L. Pedigo, MD	Nashville
Clarence R. Sanders, MD	Gallatin

ALTERNATE DELEGATES TO THE AMA

Virgil H. Crowder Jr., MD	Lawrenceburg
Donald B. Franklin Jr., MD	Chattanooga
David G. Gerkin, MD	Knoxville
Michael A. McAdoo, MD	Milan
John R. Nelson Jr., MD	Knoxville
Robert C. Patton, MD	Kingsport
Ann H. Price, MD	Nashville
Charles W. White, MD	Lexington

YOUNG PHYSICIAN SECTION DELEGATES

John W. Hale, MD (Delegate)	Union City
Steven G. Flatt, MD (Delegate)	Cookeville
Mark David Patterson, MD (Alternate Delegate)	Greeneville
Tara L. Sturdivant, MD (Alternate Delegate)	Knoxville

TENNESSEE MEDICAL FOUNDATION

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Sherri Gray, MS	Nashville

INDEPENDENT MEDICINE'S POLITICAL ACTION COMMITTEE—TENNESSEE

Board of Directors

First District	David K. Garriott, MD, Kingsport, <i>Chairman</i>
Second District	Robert N. Montgomery, MD, Knoxville
Third District	Walter B. Rose, MD, Chattanooga
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List of Advertisers

Airborne Express	265
Astra Merck	246
Boatmen's Trust	236, 237
Carolyn Avery & Associates, Inc.	264
Dodson Insurance Group	267
First Tennessee Bank	226
Jeremy Cay, Edisto Island	230
Masterson Group	264
Medical Protective Company	238
Patriot Investment Management	264
Pfizer Laboratories	228
Rural Health Services Consortium	264
State Volunteer Mutual Insurance Company	268
Sterling Healthcare Group	264
Team Health	255, 264
TN Dept. of Mental Health/Mental Retardation	263
The TMA Association Insurance Agency, Inc.	251
U.S. Air Force Reserve	256
U.S. Army	243
U.S. Army Reserve	266

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Richard M. Pearson, MD

First Names

We all observe things each day, but only at some distinct point do we become aware of them. If it is something that affects us—leaving for work in a torrential rainstorm—we notice it immediately and adjust for it. If it is more subtle, we may see it many times before we “notice” it. When the initial observation is not pursued, we may never make adjustments even though inch by inch it overwhelms us.

At a recent conference in California I noticed for the first time that name tags have changed. Because this is happening in California we can expect to notice it fairly soon in Tennessee. The new name tags have at least two lines of text. On the top line in bold, large print is your first name. On the second line in much smaller type, the variety that can be read only by stooping and squinting, is everything you thought was important—your last name, your title, and your credentials.

One of the attendees at the conference was a financial expert from London whose presentation was erudite, thought provoking, well prepared, mind expanding, and clear. His material dealt with national and world markets, insurance and reinsurance, work forces in excess of 100,000 people, and capital shifts of \$250 billion. He had traveled half a world across eight time zones and given up three days of his life to speak to us. His name was Dave. I couldn't read his last name.

Also at the conference were about 600 highly trained, intelligent, motivated individuals who listened intently. All of these individuals have one or more postgraduate degrees, extensive experience in their chosen fields, and deal with life and death matters every day. They give up security, family, and sleep to care for patients. They are physicians named Ann, Bill, Lynn, Jim, and Sue.

Finally, at the conference were individuals who have no specialized training, education, or level of expertise. Their claim to status is that they consume goods and services. Their names are legion.

As an individual, I am not particularly hung up about first names. I personally use titles to confer admiration and respect and I still refer to many individuals as Ms., Mr., Rabbi, Reverend, or Doctor. I also try to show respect in other ways, by listening and acknowledging, by caring and acting, and by working hard for the patients who rely on me. As physicians, we have responsibilities, commitments, and serious work that can't be influenced by our label. Our patient care is exemplary regardless of whether or not we are addressed as Dan or Doctor.

But we physicians are also working in many other professional arenas that do not require direct patient care. In those arenas we have been asking for and demanding “level playing fields.” What we mean by that phrase is that we want access to the same tools and advantages as our competitors in government, business, and hospitals. We should be aware that our competitors and detractors plan for all of the leveling to occur at our end of the field. This leveling can be accomplished in part by calling us by our first names, diminishing our stature, dismissing our training and experience, trivializing our agenda, dismissing the issues of quality and caring, and by conferring on us responsibility without authority. I object to this usage of “first names.”

Our message to the other participants in the health care arena should be this: “Acknowledge the importance of our patient-oriented agenda; acknowledge the education, dedication, and hard work that we bring to the task; acknowledge the pivotal role that we must play in health care; and give us a place at the table so we can find common solutions. Mutual understanding, acknowledgment, and respect lead to productive and lasting ‘first name’ relationships. Exclusion, demeaning, and denigration do not.”

R. Pearson MD

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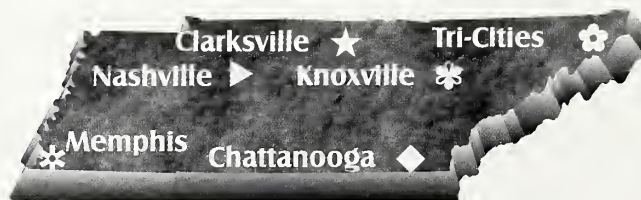
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John B. Thomison, MD

Telemedicine

If you have perchance come a'lookin' for a technical piece about telemedicine, or even an explanation of it, I can save you a lot of trouble by letting you know right up front that you have come to the wrong place. You can perhaps get an inkling of some of it, or at least its side effects, elsewhere in this magazine, but you will need other basic resources if your aim is to learn techniques. If you are of the younger generation, say below 30 or 40 years, you likely already have all that stuff at your fingertips, anyway, and there's little else you need to know. If there is, you certainly won't find it here. If you are say 50 or older, you might pick up a few pointers. But all that aside, there remain some exciting nontechnical aspects of telemedicine that you should consider, and I hope our offerings might help all of you there.

Ever since she starred in *Pretty Woman*, Julia Roberts has been a favorite of mine. She might have been one sooner except that it was the first time I had had the pleasure of her company, not being much of a frequenter of the cinema. After seeing that, I kept a weather eye out for her films on the tube. One of them was entitled *Sleeping With the Enemy*, the enemy in this case being an abusive, not to say homicidal, husband.

Ever since the personal computer arrived on the scene, I have been threatened by it, for reasons too numerous and complex to elaborate on here. I could cope with the large main frame, and even with Hal, an ostentatious bully that (or should I say "who"?) was patently fictitious and an exercise, or at least so I thought at the time, in hyperbole. But to develop any sort of relationship with such a mechanism was clearly out of the question, even for one who had always adopted *avant garde* technology in other areas.

Then the *Southern Medical Journal*, of which I was editor at the time, went on-line and I was furnished a magnificent PC with an astonishing 30 megabytes of hard disk space and 4 megabytes of memory! WordPerfect, which was the word processor software we used, and which was furnished me by the Southern Medical Association, used up nearly a megabyte of space. I learned then how Julia Roberts felt in bed with and married to a homicidal maniac.

I am writing this some seven or eight years later on a Gateway 2000 Solo notebook computer that has 1.3 *gigabytes* of hard disk space and 24 megabytes of memory. My 30 megabyte model had a tower. This one weighs 6 pounds with its battery and a modular, removable CD-ROM drive and modem. It fits comfortably in my lap, where it now rests. WordPerfect 6, incidentally, uses 8 megabytes of hard disk space, and is a very sophisticated package—much more so than I require. All that aside, I keep getting the feeling that I am working for it instead of the other way 'round, and absolutely nothing I have wastes as much of my time, both through its recurrent failure to work properly and the allure of the Internet. I am, or so I feel, sleeping with the enemy, sharing as I do the common tendency to anthropomorphize one's tormentors, one of which today is the personal computer.

There is also a human tendency these days, which probably finds its origins in the Industrial Revolution, to lionize technology, the flashier the better, and to bask in its glow, sometimes overlooking its most important though duller contributions. We carry in this issue of the *Journal* a solicited article by reporter Joe Hall about telemedicine, which is an exciting development in the realm of medical technology. The paper was initially entitled "Telemedicine: Time Saver or Cost Accelerator? Physicians Use Latest Technology To Help Patients." As you will learn if you read the article, it is not an and/or proposition. It has certainly been a time saver for many, including the doctors quoted in the article, who are actually prototypes. For them, time saved is money made. But as we shall see a bit later, it just as certainly has the potential for becoming a cost accelerator for payers through increased patient access.

The article mentions some very flashy, sometimes costly developments, such as the use of robotics to perform surgical procedures at a distance, and the less flashy though more utilitarian

electronic transmission of images and information. Where the real potential for cost escalation lies, though, is at the same time in the area that removes it for me from the enemy camp, put there by those of us who value the doctor-patient relationship, to that of friends of the sick and elderly. It is why I took the editor's prerogative of changing the title to "Telemedicine: Physicians Using Latest Technology To Help Patients." Checking with Dr. Pedigo, I find that fascination with technologic *tours de force* has pushed aside the more mundane but at the same time more practical use of telemedicine, which is to connect the patients to their doctors by means of computer terminals in the home. Though such contact is in a sense impersonal, in that the laying on of hands is obviated, the doctor-patient relationship may be enhanced by the possibility of more frequent contact with their doctor, particularly by the infirm and geographically isolated. It is this increased accessibility, for instance, with its concomitantly increased cost, that has made HCFA nervous.

It is inevitable that a tension should exist between man and his machines so long as we anthropomorphize such inanimate objects, which is likely to be forever. We slam down the telephone in disgust, for instance, when we get a busy signal for the tenth time, as though it were the fault of the telephone. Computers suffer likely not so much from inherent problems as from GIGO (garbage-in-garbage-out), even though by their very nature electronic devices are contrary creatures that seem to dote on being difficult. Above our copier is a sign that says, "Never let a machine know it has the upper hand."

Dr. Pedigo informs me that an unscientifically performed but to his thinking likely valid survey of his has convinced him that electronic physician access is being patient driven, and the real obstructionists, in addition to HCFA, are our reluctant colleagues, of which I am likely one. Or at least I have been. Nevertheless, it can be a boon to many of their patients, and in the long run likely to the doctors as well. I think that this technology is not something that will keep my doctor from either knowing me or knowing about me, as I alluded to in my accompanying editorial entitled "Eldercare." In fact, probably *au contraire*.

Perhaps we all need to open up our minds a little wider to the possibilities of this developing technology. Mr. Hall's paper should help us do it.

Eldercare

There is a certainly apocryphal account of a passerby who, observing a man sitting on the curb in a certain city, which city doesn't matter, said, "You have to be the oldest man I ever saw. I guess to have gotten so old you must have lived a very sane, clean, exemplary life, haven't you?"

"No," said the man, "As a matter of fact, I smoke two or three packs of cigarettes every day, drink at least a fifth of whiskey, and sleep with a different woman nearly every night."

"Remarkable! Quite remarkable," quoth the passerby. "Quite unbelievable. Just how old are you, anyhow?"

Replied the man, "Thirty."

And then there was Moses, of whom the Bible says that when he died at the ripe age (I started to say ripe "old" age, but the Bible doesn't, and so I won't either) of 120 years, "his eye was not dim nor his natural (read procreative) force abated."

Or take the late, great George Burns, who when he was about 75 observed that he didn't buy green bananas anymore. But he was still dancing a mean jig at his 95th birthday party at the London Palladium, and making plans for his hundredth (which he narrowly missed. He was still alive, but barely, and now it is he that is sorely missed, at least by me). At the other end is one of

the Nashville *Tennessean's* sports writers, who in his column this morning was grieving that here he was, on the slippery-slope side of 60 years old, and the proud possessor of a pair of Houston-apparently-sometime-to-be-Nashville Oilers' PSLs (private seat licenses) that are his for life. A recent stay in the hospital, about which he didn't elaborate, has made him think them not a good long-term investment, since it appears now to be a distinct possibility the Oilers might not get to play in their new stadium here in this decade. (Good luck, Jimmy—on both counts.)

All of which reminds me of one of my mother's favorite aphorisms: Pretty is as pretty does, or, as another saying goes, Beauty is in the eye of the beholder. Or, You're only as old as you feel. It reminds me of them, but it doesn't work.

The reason it doesn't work is that it is impossible to categorize people, even though we attempt it all the time. The census has a real problem, one that it shares with any demographic study. When I first started out in medicine in 1941 it was mostly pretty simple: people were black, white, or oriental. They were children (boys or girls) or adults (men or women), and you went by calendar years. Geriatrics didn't exist, because, one, not that many people lived that long, and two, medicine has changed a lot in the last half century—in more ways than one, with some bad news along with the good. I'm not going to get mired down in that morass here, because I would just be branded politically incorrect, and I have already taken pains on a number of occasions to point out that indeed I am, and proud of it. I just think it interesting that the *Tennessean* this morning described three suspects in a crime as two whites and one Hispanic.

We have in this issue of the *Journal*, a term I shall continue using just to let you know I know the difference, or lack of it, to refer to *Tennessee Medicine*, three articles not counting this one having to do with the elderly, so-called. One of them, Trauma Rounds, uses age to define the term, if one equates it with geriatric, the term the authors use. Its definition is age 65 or more. A second one, Preventive Medicine Series, simply refers to them as "older patients," an innocuous term, but makes it plain it means "older than 64 years." The third is my editorial that follows this one, in which I refer to the subject, namely me, as a reasonably active 75-year-old man, which is about as nonpejorative or nonjudgmental as one can get. I have to confess that on some days, particularly when the barometer is low and still falling, I think that's pretty damn old, and on other days I feel it isn't old at all. It's a case of your possibly being as old as you feel, but not *only* as old.

Pragmatically, of course, one has to start somewhere, and I guess 65 years is as good a place as any. At least it has the weight of convention behind it, though I'm not certain how that particular age happened to be chosen. I find it interesting that although Medicare starts at 65, the Social Security System doesn't really kick in until age 70 and a half, as though the bureaucracy is unsure of itself. (So what else is new?)

What it really comes down to in the last analysis is what every practicing doctor has found out on his own, occasionally to his sorrow: there are old young patients and young old patients, and each one of them is an individual with his own individual needs and idiosyncrasies. The information presented in our two formal papers is useful, providing it is properly applied. The proper application to the individual patient comes out of a firm doctor-patient relationship, the longer-standing the better.

This is the reason that while the HMO and the MCO, and yes, even the group practice in which the patient has not one but several primary doctors, may work in theory, it can never work to the benefit of the patient. The methods may seem cost effective, and the medical care wholly appropriate, on the front end—until the patient winds up on the cutting room floor because one of the doctors didn't know his patient. A horrible example of that appears as our Loss Prevention Case of the Month, and, if you fit into one of the above categories, say to yourself, "There but for the grace of God go my patient and I." Pray earnestly it doesn't happen, and then look to the practices in your practice.

As for me, when I'm the patient I want my own doctor, the one I picked. It makes no difference to me whether he thinks of me as a geriatric patient or not. What is important to me is that he knows me, and even more important, that he knows *about* me.

Safety First—Mostly

Split-second is a generic type term that doesn't really tell you much except that if that's how long it took for something to happen, it happened fast. We used to think of split-seconds when I was growing up in terms of tenths of a second, or at most maybe hundredths. Milliseconds came along later, but those were beyond the comprehension of most human minds, except maybe as a concept for physicists. Nowadays with the computer generation it is *de rigueur* to speak in terms of such things as nanoseconds, which have fewer ciphers by only one to the right of the decimal than I have fingers and toes, thus making it close to an incalculable number for such mathematical tyros as I. All of the above are fractions of a second, which seems to me close enough for practical purposes. But maybe not.

In any case, any of them is sufficient to make the difference between becoming a full-fledged, or with any luck an almost, what I heard referred to the other day as "road-pizza," a jarringly descriptive term that is rather unsettling when one hears it applied to one's self, which in fact it was. I am now learning firsthand, so to speak, the meaning of the term "unhandy," typing this as I am mostly with one hand. It gives one occasion for indulging oneself in whatifing and ifonlying. But even in my inconvenience, I find thank you Jesusing more appropriate, and I am more appreciative than ever of still being here, or even of being anywhere at all.

Now you might think, not unreasonably, that experience to be the basis for the title of this piece, but it isn't, or at least not directly. As I shall explain in a moment, the accident was a matter of safety only if you think it unsafe for a reasonably sound, active 75-year-old man to be out walking on his sidewalkless neighborhood streets. In my own estimation, with which you are free to concur or not, this mishap that left me with a t-shaped titanium plate and several screws in my left wrist is not a safety issue at all. It was simply the unfortunate result of several split-second decisions about converging vectors. Had either I or the car's driver chosen differently, I likely would have escaped unscathed. Speed (hers wasn't excessive, or at least not much; mine either was or wasn't, depending) and a blind curve left us little time to consider our options, and we managed to arrive at our end point at approximately (fortunately) the same time because she chose to pass in front of instead of behind me, either of them an option of hers. When I looked down and saw not my life but the hood of the automobile passing before my eyes, my synapses told my hands it was time to get me outa there, and so they pushed me off the car, the force adding sufficient spin to land me on the pavement, in relatively good condition generally but with a misshapen wrist.

The safety issue I have before me came to mind not from the accident itself, but out of my hospital experience. Having been without food or drink for 24 hours, despite having had a general anesthetic I was eager for both when I returned from surgery. Since it was too late for supper, I was brought a sandwich, some chips, a cookie, and milk. The recent monkeying around with my larynx in the placement of a laryngeal hood, plus the dryness from previous medication, made supper something less than the anticipated delight. Breakfast, though, was different. Not only that, it was different from any sort of hospital meal to which I have lately become accustomed. It reminded me of the good ol' days. Though there are those who might think the breakfast itself unsafe, I generally ignore their suggestions, and I certainly would have in this instance. It was a touch of class, I thought, so missing from much of today's living, as in the days before banks of thermal trays stacked row upon row on carts were disassembled on the floor and their individual parts dumped unceremoniously on bedside tables. Instead, in walked a nurse bearing a tray laden with orange juice, cream of wheat, eggs and bacon, a biscuit with butter and jelly, and coffee, all served in a civilized way in individual plates and dishes—and with metal utensils. I ate it all. And, "What," she asked, "would you like in your coffee?" In response to my thanks, and my congratulations, the nurse explained that as to the food, the hospital had recently changed suppliers because of the better quality. In addition, they had

found also that during serving, the food in the thermal trays was handled by four sets of hands, whereas only two sets are involved when it is served in the individual dishes. The decreased chance for contamination and increased patient satisfaction made it worthwhile.

How delightfully novel, I thought, having seen no contrary evidence, to find a health care institution these days that considers safety and patient satisfaction ahead of cost, particularly when the *Wall Street Journal* reports that many, even most, large hospitals now tie the CEO's salary to cost cutting. But don't get me started on that again. I have had only limited experience with that particular hospital, and this may or may not be characteristic of it, but I somehow got the impression it just might be. Some with a long and close connection tell me things there are not the way they used to be, but then where are they? Certainly not at my bank or my auto emporium, or anywhere else I can think of. At the hospital where I used to work? It is to laugh—or perhaps weep. I chose the particular hospital I was taken to because its ER is considerably the closest to my home, no small consideration during the morning rush hour, and I knew, too, I would be in good hands. The facility is presently undergoing expansion, and some areas are in disarray, but its appointments are tasteful, and it has a homey quality. I was well treated, and not too much inconvenienced, considering.

I was reminded by the events of the day that though we need to do everything reasonable to assure the safety of ourselves and others, safety is relative, and it is easy to become a slave to the notion. I therefore reiterate here my previously expressed conviction that one cannot be protected from every eventuality, and trying to be is simply a frustrating exercise in futility. Safety is elusive, and in its pursuit quality of life, instead of either the saving of money or the mere prolonging of physical existence, should be the desired end. For the sake of the first I intend, Lord willing, to continue my usual walks.

After a meeting in San Francisco some years back, my intended drive down the coast to San Diego and Borrego Springs was washed out along with the coastal highway by recent heavy rains, leaving me casting about for an alternative. After spending my first free night in Carmel, my search ended the next morning at the Carmel Mission, where I happened upon a small booklet describing each of the 21 California missions. That discovery furnished a diversion not only for that California visit, but for several others during the subsequent two years or so, during which I followed the entire route taken by Father Junipero Serra, founder of the missions, and his little band of Franciscan padres.

During a 54-year span beginning in 1769, to minister to the California Indians the Franciscans established the chain of missions that are scattered along *El Camino Real*, the 600-mile stretch from San Diego to Solano in Sonoma, for the most part the segment of present-day Highway 101 from San Francisco to San Diego. The missions today vary from the few flattened adobe walls, partially restored, at Soledad, near Santa Clara, to the beautiful grand church at Santa Barbara, the only mission to have survived the Mexican government's secularization of the missions and removal of the Indians from their protection. To the present day it has remained continuously under the control of the Franciscans and their ministry to the Indians.

The way of life of the industrious, devout padres was simple, and what living quarters of the missions are open to public view are plain and Spartan, usually furnished with a cot, a desk, a straight chair or so, and a prayer bench. The only decoration commonly found on the plain, whitewashed walls is a crucifix.

Looking about my hospital room on returning from Recovery, I saw that except for its comfortable modern hospital bed, it was timeless, generic hospital, without frills. It contained everything necessary to the well-being of the patient and a visitor or so, and nothing more, save perhaps the television set mounted high in one corner, which served, as well as a diversion, as an effective teaching tool for patients. That and the hospital paraphernalia aside, the room's appointments bore a close resemblance to those of the monks' cells in the missions. On the wall before me were a clock and a calendar, and, as in the cells, a crucifix—a comforting reminder that though the world offers no assurance of safety, there still remains one solitary, eternal, and eternally available safe haven.

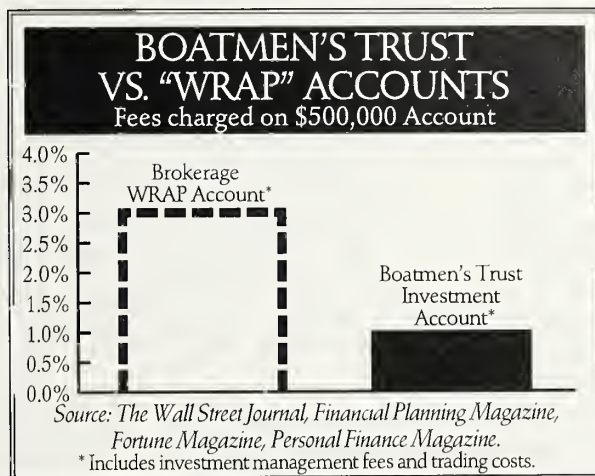
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Telemedicine: Physicians Using Latest Technology To Help Patients

Joe Hall

It wasn't so much an interest in technology as it was a search to survive an overwhelming rural practice that led McMinnville radiologist Wendell McAbee, MD, to the world of telemedicine.

For a number of years in the late 1980s McAbee was the only radiologist serving Warren, Coffee, Dekalb, and Cannon counties in Middle Tennessee. The workload was heavy and the demands intensive for a single radiologist, particularly one who had to assist in patient care at a handful of regional hospitals. "I was the only radiologist for four counties for a long time," he says. "In order to provide a better service for those counties, I had to make the connection."

The connection, as McAbee calls it, is a network that links him with those four counties and makes him available at all times at the four regional hospitals. Using a monitor at his practice office—or even at home—McAbee can view radiographic images of patient x-rays from any of the four counties and provide a diagnosis within minutes.

From McAbee's perspective, the picture is clear: he's providing better service for the physicians and patients in the region and he's doing it more efficiently. Without the radiographic application, service to patients would stall. "It would be virtually impossible to manage the practice without this system," McAbee says. "Things have changed and now I have two partners. But this is still very, very helpful. The area has grown, and three radiologists could not physically handle this region and all the hospitals and patients. This allows us to provide more complete service and do everything more efficiently."

McAbee's use of digitization and modems to view radiologic images is just one of a number of increasingly common applications that fall under the telemedicine umbrella. Tele-

*"Bill Gates and the cable companies
will have as much or more to do
with [telemedicine] than we
in the medical field will."*

—Thurman L. Pedigo, MD, Nashville

medicine largely refers to the use of communications equipment—whether facsimile machines, computers, or land-line or cellular modems—to assist and enhance the delivery of health care services.

Physicians have been using computers for more than two decades to facilitate the in-

formation process, typically for billing and patient records. Technologic progress over the past 10 years has made it possible to digitize and transport images such as electrocardiograms and x-rays. These advancements continue to push the practice of medicine—and the methods by which health care services are delivered—into the future.

The emerging world of telemedicine means the formation of electronic relationships, a worldwide connection between physicians and patients. Today, telemedicine spans a diverse range of applications, from simple uses for patient records and imaging to more unconventional—and surprising—functions such as robotics. Through the use of computers and video equipment, physicians can perform surgical procedures on a patient without their even being in the same room, or in the same city for that matter.

Telemedicine may also mean improved patient results; applications being used now enable surgeons to conduct procedures on "computer patients" to view results before the actual surgical procedure is performed.

An even bigger picture is emerging on the horizon. A recent issue of the *Journal of the American Medical Association* hints at a medical future that has a physician viewing chest x-rays on her home entertainment center, then prescribing anti-hypertensive medications via electronic mail. In the future, the cellular phone (complete with screen and keypad) and computer, it seems, will be as utilitarian as the stethoscope.

And the future, suggests Thurman Pedigo, MD, isn't that far away. Pedigo, a McMinnville family practitioner for more than 30 years, believes the rising generation of medical school students—a generation that grew up using computers—are

Joe Hall, formerly a health writer for the *Nashville Business Journal* and the *Memphis Health Care News*, is currently a consultant with The Ingram Group in Nashville.

more technologically inclined and will take telemedicine to greater, more elaborate levels. Still, Pedigo says, "Bill Gates and the cable companies will have as much or more to do with it than we in the medical field will." Pedigo suggests that "there will be some uses that are pretty far out there, that some people today will have trouble even understanding." Not only will physicians be able to deliver high-tech care, but he believes that patients will some day soon communicate with a physician via their home television/computer.

So far, some of the most remarkable and efficient applications, such as those of McAbee and his partners in McMinnville, have taken shape in rural areas. Pedigo also practiced in McMinnville, and in 1970, well ahead of even most urban physicians, began using a computer for accounts receivable. That curiosity interest expanded over the years, and as technology allowed he used a PC for information retrieval.

"We were using technology throughout that period to complement our practice and improve the utilization and quality of care to patients," says Pedigo, now a consultant to Vanderbilt University School of Medicine and interim chairman of its department of family medicine. Besides a fascination with computers, Pedigo has a keen interest in bioinformatics, which is the use of organized information and data for the delivery of health care.

Pedigo's eyes were opened to the full benefits of telemedicine when he observed McAbee and his use of scanners and monitors to observe radiographic images. "I remember leaving a medical society meeting with him, and he had an instrument hooked up so that he could read CAT scans in a town that was 20 miles away. He got the information on his monitor and then gave an interpretation to a doctor in the emergency room at the hospital."

Vanderbilt is among the regional leaders in the deployment of telemedicine services. It also has connections with Sumner Regional Medical Center and with Bedford County Hospital. Those electronic relationships, as Vanderbilt Radiology Operations/Systems Director Mark Moffitt says, allow the transfer of nuclear medicine studies over ISDN lines. The transfers entail anywhere from two to five images at eight megabytes each, taking about three minutes to complete. The material is studied at a PC work station, and interpretations are returned in a matter of seconds. "It took a while to build these relationships, and the level of trust necessary to practice medicine with this type of technology," Moffitt says.

Charles Womack, MD, a Cookeville urologist, was introduced to telemedicine around 1990 when he had an article on an uncommon procedure sent to him by facsimile 15 min-

utes before surgery. Today, he and his partners at Upper Cumberland Urology have been on-line with neighboring Cookeville General Hospital for the past nine months. Working from a computer, Womack's nurses and office assistants can, using the right security code, access the hospital's system through a dedicated phone line and get patient information, laboratory work, and x-rays. All of this previously meant a lot of time at the facsimile machine and walking back and forth to the hospital. "We're much more efficient today than we were," Womack says. "Before, if we needed something at the hospital, we would call and be placed on hold forever. We don't duplicate our efforts now; it's all much more efficient for us—and for the patients, too, I think."

McAbee and other radiologists use telemedicine for perhaps its most fascinating application—to receive and view images, and then provide a diagnosis. He can share these visuals and gain opinions from as near as Nashville and as far away as New York or Hong Kong.

Here's how it works: any of the four hospitals McAbee works with can digitize a radiographic image and send it by modem to a computer at the site of his practice. The receiving computer changes the incoming signal back to analogue, and then the image is displayed on a monitor. The modem communication is kept intact, and the image can be enlarged or certain areas of the picture can be isolated and zoomed in on. "This type of digitization of images on film is the future of radiology," McAbee says.

And it's getting easier. New programs enable a physician to view these images on just about any desktop PC. All that's needed is a modem and a dedicated phone line. There are stiff barriers, though, to the development of more comprehensive telemedicine networks. While the greatest impact appears to be in rural America, cost often makes infrastructure development prohibitive. With rural hospitals struggling with declining margins, the prospect of committing upwards of \$100,000 toward telemedicine systems is sometimes difficult.

And while telemedicine can make it easier for the physician and the patient, there's not a whole lot of evidence to suggest that these technologic advances contribute to reducing health care costs, Pedigo says. If anything, telemedicine increases patient access, which in turn could instead increase costs, he says. Pedigo cautions also that there exists a line between the use of telemedicine in rural areas and the direction of telemedicine in suburban America. There are those, he says, who criticize telemedicine as too impersonal. "Some people believe it will be an obstacle to delivering good health care, that it will get between the doctor and the patient." □

*The emerging world of telemedicine
means the formation of electronic
relationships, a worldwide connection
between physicians and patients.*

Heri, Hodie, Cras . . . Yesterday, Today, and Tomorrow

Louis A. Cancellaro, MD, PhD
Immediate Past-President, Southern Medical Association

Heri, Hodie, Cras . . . Yesterday, Today, and Tomorrow . . . Always medical excellence. The ideals espoused by these phrases ring as true today as they did when the Southern Medical Association (SMA) was founded in 1906, and with continued strong leadership will remain so into the next millennium.

During this address I invite you to join me on a brief journey. It is however an unusual journey, one that will require you to free your imagination, since we will travel back in time. Let's go back to the time when Queen Victoria in England was celebrating her golden jubilee. That was also the time when Cezanne and Monet were at the height of their career, and the Impressionist era was in transition to Post-Impressionism, when such artists as Van Gogh and Gauguin were gaining prominence. That was also the period when Gilbert and Sullivan composed their *Yeoman of the Guard* and Verdi in Italy was composing *Othello*. The year is 1888.

This was the year when another Louis inaugurated his Institute in Paris, the Pasteur Institute, with these words: "Of this we may be sure: that science, in obeying the law of humanity, will always labor to enlarge the frontiers of life."

There is no doubt that these frontiers are much larger now than ever before. At that time, the number of specialties was no greater than the fingers of one hand, whereas now they are too numerous to count, and more continue to emerge. This has inevitably led to specialists restricting their practice to a very limited field and risking losing sight of the patient as an individual.

It is of interest to note that Hippocrates described clinical medicine as the practical application of intelligent observation, and insisted that it is the sick man who matters, and not man's theory of sickness. The entire patient must be heeded, he said, and the whole of the surroundings noted. Hippocrates

advocated holistic medicine 25 centuries before it became a contemporary issue. Unfortunately, his teachings have not been followed. Medicine has continued to become more specialized, leading to a proliferation of associations, each with a very narrow focus to satisfy the pursuit of intellectual provincial interests, namely subspecialization, but oftentimes losing sight of the whole patient.

*Today's medicine directly affects the
health of generations to come, the
condition of their society, and perhaps
even the survival of their world.*

Like most other associations, ours has developed a number of specialty sections, now numbering 27; two of these sections have been developed this year. Our Association, however, is unique in that while each section is distinct, none is separate from the entire organization; all sections are united without losing

their individual identities. This very meeting is proof of that. The first scientific assembly in 1906 offered a number of sessions in medicine, surgery, and ophthalmology that would be well attended today. From its inception the SMA elected to be apolitical, and to focus on education. Diseases became the agenda in the continuing discourse on the relationship of medical responsibility and individual culpability.

Issue after issue of the *Southern Medical Journal*, and year after year in scientific assemblies, leading southern physicians in our Association advanced the cause of education and social commitment among members of their profession. Of course, some diseases of concern at that time are now resolved, but the principles governing our assemblies have not changed.

Expanding medical frontiers and shifting trends mandate active medical education for physicians. The SMA has responded to this mandate throughout its history by providing opportunities through the constant of education.

When overcrowding of the profession by undertrained practitioners became a concern, SMA responded by providing courses designed to upgrade the quality of medical education. Recognizing shifts first towards specialization and subsequently towards primary care, the SMA offered courses in practical and clinical guidelines, information in practice

Presented as the President's Address at the 89th annual assembly of the Southern Medical Association, Kansas City, Mo., November, 1995.

management, specialty workshops, and clinical symposia for primary care physicians. Needs assessments regularly poll the membership to collect and reflect the most frequently requested topics by practitioners.

Debates over academic versus technical training gave rise to hands-on courses and training for physician staff, and computer and CD-ROM video conferences, targeting more than 1,000 sites, on the internet. We must be ready to present medicine's latest information on the most advanced technologies. Frontiers are expanding too rapidly for traditional printed media and structured classroom format to keep up with the changing needs. Medical education will soon depend on a pentium chip able to achieve 2 billion decisions or computations within the space of a second, transmitting electronic data on fiberoptics over a system disseminating this data throughout the world almost instantaneously.

Keeping in mind that the practice of medicine is not only a science, but also an art, and keeping in mind the frequent ethical problems physicians often face, ethical issues often played a prominent part in our meetings. It is evident from assembly proceedings and the *Southern Medical Journal* that a physician's social commitment was considered an intrinsic element of practicing medicine.

Viewing medicine in retrospect offers a perspective to better understand our responsibility to a national and global health community. In the crucible of sickness, societal truths are illuminated dramatically, as is our relationship with physicians and patients, past and future. The study of medicine through the ages will help the student develop a kinship with patients and practitioners of the past as well as a sense of humility with respect to disease and nature.

We must remember, however, that it is the present need that will always determine our immediate concern. As Bernard Baruch so incitefully stated: "I am interested in physical medicine because my father was. I am interested in medical research because I believe in it. I am interested in arthritis

because I have it." Present need is most often the inspiration for medical research and great breakthroughs. The SMA has always encouraged original research. Funds are awarded to budding researchers and this year, for the very first time, \$26,000 will be awarded to outstanding papers presented during this annual meeting.

The rapidity of progress is indeed exciting. From Crick and Watson's discovery of recombinant DNA, four decades elapsed until the human genome project was launched in 1990, and yet we are still in the infancy of that science. Fur-

ther advances, as the study of DNA, myoclonal antibodies, the NIH human genome project, and research activities by independent institutions arouse ambivalent emotions. On one hand, we are awed by the prospect of instant communication, of genetically engineering certain diseases out of existence. We are awed by "smart pills," and potential therapies for cancer,

neurologic disorders, and cystic fibrosis. On the other hand, we are dismayed by reports of commercially patenting gene fragments, in effect an attempt to copyright humanity, and by the Orwellian specter of international commerce in control of the deepest secrets of life.

In the 19th century, Oliver Wendell Holmes said that the life of a child begins 100 years before that baby is conceived. Our infant knowledge of genetics and DNA reveals the truth in that statement. Today's medicine directly affects the health of generations to come, the condition of their society, and perhaps even the survival of their world.

As physicians we are part of an art and science and a body of knowledge that has no beginning. Ladies and gentlemen, it is now time to return from our trip. We must bear in mind that if medicine fails to base exploration into the frontiers of life on moral and ethical foundations, if medicine ceases to consider welfare of the patient as the central purpose for research, and if medicine is operated on the sole basis of good business and profit margins, then medicine will cease to be great. □

*The study of medicine through the ages
will help the student develop a kinship
with patients and practitioners of the
past as well as a sense of humility with
respect to disease and nature.*

Loss Prevention Case of the Month

Who/Where Is My Doctor?

J. Kelley Avery, MD



Dr. Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

On the 16th of the month, this 64-year-old woman entered to the emergency department (ED) of her community hospital with chest pain. She was a moderately obese two pack/day smoker, with a questionable history of diabetes and a strong family history of "heart trouble" and diabetes. She also had a long history of indigestion and heartburn, frequent headaches, and chronic back pain. She described her chest pain as aggravated by exertion, accompanied by some dyspnea, and having been present off and on for a week. She also described another type of chest discomfort that was increased by deep inspiration and relieved by holding her breath. She was seen and examined by the ED physician, who found her in no distress, with vital signs within normal limits, her blood pressure being 140/88 mm Hg. The chest was clear, heart sounds normal, and the abdomen soft, without tenderness or

masses. The neurologic examination was negative. She was admitted to the hospital to the service of her personal physician, Dr. Green. Orders were written for serial EKGs, and enzyme determinations every eight hours times three, an AP/lateral chest x-ray, Nitrol paste, Cardizem 30 mg daily, and Zantac 150 mg twice a day. He also scheduled an upper GI series (UGI).

The EKGs were interpreted by computer and said to show

evidence of a possible subendocardial injury on admission. Over the next 12 hours the repeat tracings became less ominous, but were still abnormal and compatible with some lateral wall ischemic changes of undetermined age. The enzymes, including the cardiac isoenzymes, the CPK, and MB band were within normal limits.

On the 17th, the day following admission, the patient was seen by Dr. White, covering for Dr. Green. He wrote a note documenting the reduction of chest pain since her admission, and noted that UGI had been ordered because of her complaints of "indigestion." The nurses noted fever of 102.2°F, which was not commented on except that there was a telephone order by Dr. Green to give Tylenol for fever and to begin Cefitin 250 mg orally four times a day. The nursing notes did not document whether or not the patient was visited by Dr. Green. The second day of her hospital stay, the 18th, the patient was apparently seen by Dr. White, who ordered back x-rays because of the patient's complaints of back pain. Dr. White also noted a "decrease in chest pain," and that the patient was to have the UGI that day. The UGI was later reported as showing only some exaggerated esophageal contractions in the lower third. EKGs and enzyme studies done that day were essentially unchanged. The nursing notes revealed a good day, with no changes in the patient's vital signs.

On the 19th, Dr. White wrote a progress note indicating that there was barium in the bowel, which made the back films unsatisfactory. The nurses noted no change in the patient's condition. She had no chest pain and had been resting quietly all day. On the fourth hospital day, the 20th, Dr. Green verbally ordered hydrocodone as needed for pain. A progress note that same day by Dr. Green recorded some chest pain and shortness of breath that AM. He also ordered a repeat EKG, which continued to show the nonspecific abnormalities without significant change. The pain is recorded on the nursing notes with the added description that it was worse on deep breathing. The shortness of breath was referred to in the nursing notes by the patient as "not unusual for me." She was given some of the pain medication for the chest pain and was said to have had no pain for the rest of the day.

On the fifth day of her hospitalization, Dr. White reported that the spine films showed "arteriosclerosis of the aorta and

degenerative disc disease." On the same day the patient complained of nausea and attempted to induce vomiting by sticking her finger down her throat. A standing order for Phenergan was given by Dr. Green. Dr. White noted that the patient had experienced some "chest and left shoulder pain this AM." The heart and lungs were negative on auscultation. The EKG was reported again as abnormal but essentially unchanged except for occasional premature ectopic complexes. On the sixth day in the hospital, there was more chest pain, and a nitroglycerin patch was applied. She complained of nausea, ate poorly, and was said to have a "nonproductive cough." The nurses noted an "audible wheeze" on auscultation of the chest. On this day the nurses reported that the husband had become very upset because Dr. Green, her regular physician, had seen her only one time since admission. The following morning, after one week in the hospital, the patient signed out against medical advice and went to another facility in a nearby large city.

On review of her chart from the community hospital, the admitting physician in the larger institution concluded that there was a likelihood of some myocardial injury on her admission there, and that she might also have some pneumonia. Two days later there was a suggestion on the EKG of further myocardial injury, although this was equivocal. Echocardiography revealed some left ventricular hypertrophy and "severe mitral regurgitation." EKGs were reported as "consistent with inferior posterolateral infarction, but unchanged" from the time of her admission to the second hospital. There was also the suggestion that the patient was in some degree of congestive heart failure.

On the sixth day of her stay in the second hospital, the patient died from a sudden bout of ventricular tachycardia. All attempts to convert the arrhythmia failed. A lawsuit was filed against the community hospital and Dr. White.

Loss Prevention Comments

One could not say that this patient was benefitted by her stay in the second hospital, but her care in the first hospital left much to be desired, and could have contributed to the end result. It is obvious from the events that Dr. White was expected to see this patient while covering for Dr. Green, but we cannot be certain that Dr. White ever understood that, and it was documented nowhere in the record! Dr. White was asked in a hallway conversation the day of her admission to cover for his colleague. He understood that this coverage was to continue for the next two days. The nursing notes do not help us to determine just who, if anybody, was seeing this patient regularly. Dr. White is noted in the nursing notes and the progress notes to have seen her on at least three days of her hospitalization, but with the "verbal and phone" orders and few progress notes by the physicians it is difficult to tell. One thing is certain about the record, and that is that the discharge summary was dictated by Dr. Green about ten weeks after the fact of her hospitalization on his service in the community hospital, and eight weeks after her death in the second hospital.

It is obvious that the anger that developed toward Dr. White because of the confusion over who was to see the patient led to the lawsuit against him. This is a case where the lack of a clear understanding between the two doctors, one that was supported by the record, was critical to the filing of the lawsuit and could have contributed to her death in the second hospital. A simple order on the chart and a brief progress note by Dr. Green, the patient's primary physician, that Dr. White was to cover for him for a specified number of days could have prevented the litigation. The misunderstanding and finger pointing between the physicians made it unwise to try this case, and it was settled for a significant amount of money. □

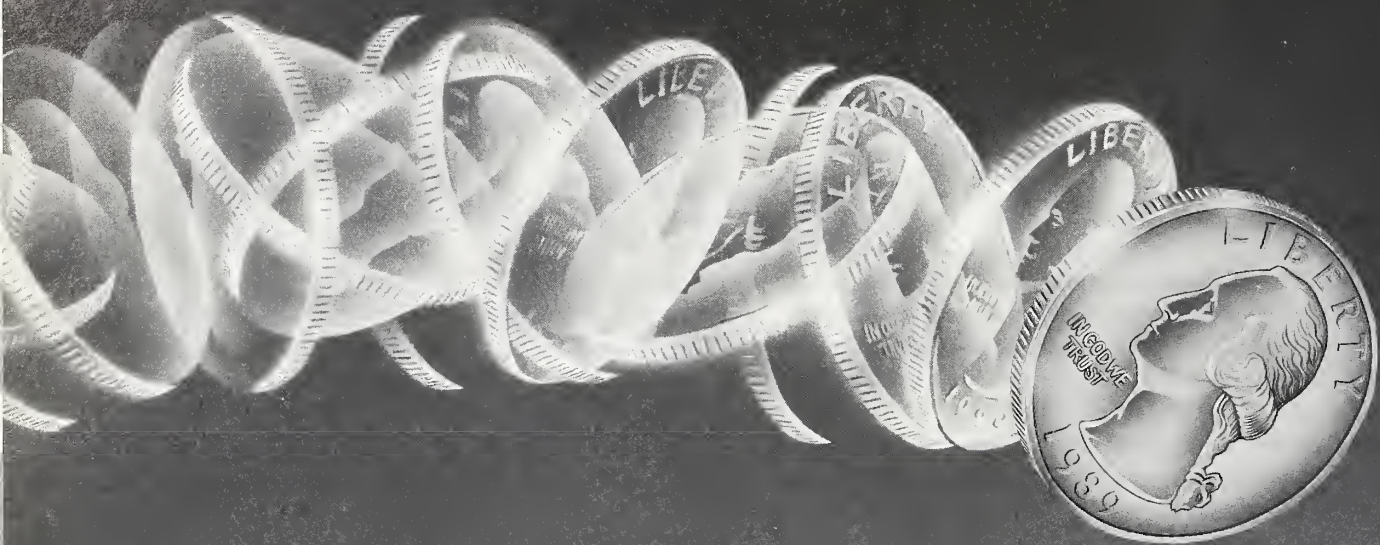
ERRATUM

In the June 1996 issue of *Tennessee Medicine*, there was an error in Resolution No. 2-96, which was adopted by unanimous consent. In the opening session of the House of Delegates, several editorial changes were made to the Resolve that were left of this publication. The Resolve for Resolution No. 2-96 should read as follows:

RESOLUTION NO. 2-96 Reaffirmation of Resolution No. 10-89 (Ban on Smoking in Public Places)

Charles T. Womack, MD, Chairman
TMA Board of Trustees

RESOLVED, That the Tennessee Medical Association be a leader in anti-smoking activities and continue its efforts to encourage the General Assembly and the executive branch of Tennessee state government to implement a smoke-free policy in all state buildings and facilities and in all public gathering places, such as theaters, schools, hospitals, outpatient clinics, public health department clinics, public transportation vehicles, and restaurants.



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Original Contribution

Cat Scratch Disease Presenting As Multifocal Osteitis

Gail Gallemore, MD and Kim Worley, MS-III

Introduction

Cat scratch disease (CSD) has been recognized as a clinical entity since 1931 when Dubre described a febrile syndrome associated with a cat scratch. The etiologic agent was unknown until 1983, when Wear described the gram-negative bacillus on gram stain of infected lymph nodes using the Warthin Starry silver impregnation stain. Since then a debate has raged over classification of the organism. Serologic testing now makes the identification of CSD easier. We will be able to describe a wider range of the clinical spectrum of the disease as the diagnosis becomes easier. This report describes a case of CSD with a fever of unknown origin and migratory bone pain.

Case Report

A 10½-year-old white boy was referred to the infectious disease clinic with a three-week history of intermittent fever, the temperature ranging up to 105°F. He had weakness, fatigue, and anorexia with weight loss. He initially saw his own physician for crampy abdominal pain for four days without nausea, vomiting, constipation, or diarrhea. He had rebound tenderness in the right lower quadrant and an elevated WBC count with a left shift. A surgical consultant believed it was not a surgical problem and released him. Over the next three weeks, the patient sought medical care six times for shaking chills and right hip pain. Laboratory evaluation revealed a normal chest x-ray, normal abdominal CT, normal chemistries, and negative febrile agglutinins. ESR was 54 mm/hr.

He was referred to our clinic with a 10-lb weight loss, and he now had left lower rib pain with deep breathing, continued fever spikes, and progressive debilitating fatigue. Further history revealed that a kitten he liked to play with was

living in his cellar. The patient had been healthy until this illness.

The physical examination revealed lethargy, a temperature of 101°F, and no other positive findings. He had no skin lesions, lymphadenopathy, hepatosplenomegaly, or any point tenderness.

Laboratory findings revealed a normal CBC, normal biochem 28, and negative toxoplasma and cytomegalovirus serologies. Intermediate strength PPD was negative. The mono spot test was repeatedly negative and the amylase was normal. No blood was found in the stool, and an abdominal ultrasound and chest x-ray were normal. The EIA for *Bartonella henslae* showed an IgM of 51 (>15 EIA units is positive) with a negative IgG. A bone scan (Fig. 1), done before the *Bartonella* titers were known, showed six sites of increased uptake: the right proximal femur, the L₁ and T₄ vertebrae, the left mid-cervical spine, and the right 8th and 11th ribs.

A bone marrow aspirate showed a reactive marrow from which no organism was isolated. The plain x-rays of the involved bones were normal. MRI of the right femur showed minimal changes, with an altered signal in the intertrochanteric area with no lytic lesions. A bone biopsy of this area was sent to the AFIP and did not reveal any organisms on Warthin Starry silver impregnation staining. No organisms grew from the biopsy specimen in our laboratory. The histology revealed a reactive marrow without granulomas.

Five weeks from the onset of his fever, the patient became afebrile, his appetite returned, and the fatigue gradually resolved. No medication, specifically antibiotics, had been used, as the results of the EIA were not known before the symptoms resolved. Cat scratch antigen skin test was applied three months from the onset of the symptoms and was positive at 22 mm × 18 mm. The repeat bone scan at this time was normal except for increased uptake at the biopsy site. Nine weeks into the illness, *B. henslae* IgM ab titers had declined from 51 to 32, while IgG ab was positive at >120 (>15 EIA units is positive).

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Figure 1. Bone scan showing multiple sites of increase uptake at the right proximal femur, L₁ and T₄ on the left, the mid-cervical spine, and the right 8th and 11th ribs.

Discussion

Cat scratch disease may typically present itself with lymphadenopathy following contact with an immature cat. Other common findings include vague symptoms of fever, fatigue, and anorexia. In past studies, 5% to 20% of CSD cases have been documented as having no lymphadenopathy.¹⁻³ Positive bone findings have been described on bone scan.⁴ An inflammatory process suggesting osteomyelitis is usually found, and all cases reported thus far have involved only single sites.⁴⁻⁶ Our patient had six bone lesions that did not develop to the point of lysis before the infection cleared.

While working through the differential diagnosis of fever of unknown origin and migratory pains, only the history led us to suspect CSD. Upon further investigation, even though our patient had no lymphadenopathy, he did meet most of the criteria necessary to diagnose CSD, including frequent contact with a cat, a positive skin test for CSD, and negative PPD skin tests.² The negative Warthin Starry silver impregnation stain of the bone did not exclude diagnosis of CSD. Others have described a negative stain as the disease progresses, particularly in the bone.⁷

Multifocal osteomyelitis is another enigma in the spectrum of infectious disease of bones for which no agent has definitively been identified. Since *B. henslae* is difficult to grow, one must ask if it may be playing any role in this illness. Most victims with multifocal osteomyelitis recover without treatment, as our patient did.

The diagnosis of CSD should be considered in any case of a child with a fever of unknown origin, even without lymphadenopathy.⁸ A thorough history and physical examination, with proper laboratory work and other studies, can help narrow the differential and lead the physician to the correct diagnosis. Improving serologic techniques will aid us further by giving a clearer picture of the spectrum of CSD. Multifocal bone lesions have not been previously described with CSD. Our case was unusual in that the patient showed two atypical characteristics, the absence of lymphadenopathy and the presence of multiple bony lesions. □

Acknowledgments

We thank Dr. Andrew M. Margileth for phone consultation and supplying the cat scratch antigen, and also Dr. D. J. Wear of the AFIP for staining the bone for *Bartonella henslae*.

References

1. Margileth AM: Cat scratch disease. *Adv Pediatr Infect Dis* 8:1-21, 1993.
2. Klein J: Cat scratch disease. *Pediatr Rev* 15:348-353, 1994.
3. Margileth AM: Cat-scratch disease: etiology, diagnosis, and therapy. *Infectious Disease*, Oct 1993, pp 38-43.
4. Walterspiel JN, Nimityongsul P: Positive bone scan in cat-scratch disease. *Pediatr Infect Dis J* 6:944-945, 1987.
5. Muszynski MJ, Eppes S, Riley HD: Granulomatous osteolytic lesion of the skull associated with cat-scratch disease. *Pediatr Infect Dis J* 6:199-201, 1987.
6. Nimityongsul P, Anderson LD, Sri P: Cat-scratch disease: orthopaedic presentation. *Orthop Rev* 21:55-59, 1992.
7. Carithers HA: Cat scratch disease. *Am J Dis Child* 139:1124-1133, 1985.
8. Malatack JJ, Altman HA, Nard JA, et al: Cat-scratch disease without adenopathy. *J Pediatr* 114:101-103, 1989.
9. Regnery RL, Olson JG, Perkins BA, et al: Serological response to "Rochalimaea henslae" antigen in suspected cat-scratch disease. *Lancet* 339:1443-1445, 1992.

Trauma Rounds

Care of the Geriatric Trauma Patient

Sherry M. Melton, MD, Joe H. Patton Jr., MD, Sean P. Lyden, MD, and
Martin A. Croce, MD

Introduction

Trauma is thought to affect the adolescent and young adult more than the geriatric population. Geriatric patients (≥ 65 years old) have a significant mortality rate when involved in trauma. Although they represented only 12.7% of the population, the elderly accounted for 29% of trauma-related deaths in 1991.¹ This subgroup is growing disproportionately and is predicted to make up 23% of the population by 2050.² Specialized care of the injured elderly patient will therefore become more important as the composition of the population changes.

The contemporary elderly are living longer and are in better health in their later years, allowing them to be more physically active and mobile than their predecessors. Despite the increased activity, the elderly are predisposed to injury due to deterioration of their senses and decreased ability to react to environmental hazards. In addition, preexisting medical conditions often complicate injury management in terms of care and resource allocations. The health care system of the future must be prepared to care for geriatric patients involved in multiple trauma.¹

Case Reports

Case 1. A 78-year-old male pedestrian struck by a car was transported by ambulance to the Presley Regional Trauma Center 20 minutes after the injury. Upon presentation he had a heart rate of 78/min, systolic blood pressure 110 mm Hg, and respiratory rate 18/min. His Glasgow Coma Scale was 15 and his Trauma Score was 16. He had abrasions about the face, crepitus over the left anterior chest, and decreased breath sounds on the left. His abdomen was soft, with suprapubic tenderness. His pelvis was unstable to lateral compression and painful to palpation on the right side. Rectal examination was heme-negative with normal tone and prostate position. He had a deformity of the left arm and right thigh, but all distal pulses were intact and the neurologic examination was normal. A chest x-ray revealed a pneumothorax, for which

a 36 French chest tube was placed. The pelvic x-ray revealed right superior and inferior pubic rami fractures and a right sacroiliac joint separation. Cervical spine x-rays were normal. Additional films confirmed a right femur and left humerus fracture. His hematocrit was 28%, arterial blood pH 7.28, P_{CO_2} 38 mm Hg, P_{O_2} 110 mm Hg, and bicarbonate 20 mEq/L. There was a base deficit of 8.0; urinalysis was normal. Resuscitation consisted of 2 liters of crystalloid and 4 units of packed red blood cells (PRBCs). A pulmonary arterial (PA) catheter and arterial line were placed. His initial CO was 4.2 L/min, pulmonary capillary wedge pressure (PCWP) 8 mm Hg, and SVO_2 52%.

The patient's workup included an abdominal/pelvic CT scan, which was normal except for a large retroperitoneal hematoma associated with his pelvic fracture. Despite transfusion his hematocrit remained at 30%. A pelvic external fixator was placed while the patient was still in the resuscitation room. Resuscitation was continued with PRBCs, FFP, and crystalloid to maximize tissue perfusion. Post-resuscitation hemodynamics showed a CO of 6.8 L/min, PCWP 15 mm Hg, SVO_2 68%, and hematocrit 35%. He was taken to the operating room eight hours after admission for stabilization of his right femur. His left humerus fracture was treated with a cast. The patient tolerated these procedures without difficulty. He remained in the trauma ICU for 21 days due to an episode of pneumonia and ventilator dependence. He was ultimately transferred to the ward where he convalesced another two weeks. After two months in rehabilitation he returned home at his previous functional level.

Case 2. An 84-year-old woman was transferred to the Presley Regional Trauma Center from an outside hospital six hours after falling down a flight of steps outside her back door. She had been found outside three to four hours after the fall. Her systolic blood pressure was 70 mm Hg and her temperature was 88°F at the outside hospital. Upon arrival at the trauma center she was awake with a Glasgow Coma Scale of 15, heart rate 98/min, systolic blood pressure 100 mm Hg, respiratory rate 12/min, and temperature 92°F. Her Trauma Score was 16. Physical examination revealed soft tissue damage to the face on the left, but her head, neck,

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chest, and abdomen were unremarkable. Her left wrist was deformed, with a wound over the area. The right arm had a large soft tissue defect, and her right thigh had a deformity suspicious for a femur fracture. Her chest, pelvic, and cervical spine x-rays were all within normal limits. Additional films confirmed a right femur fracture and fractures of both bones of the left forearm. A head CT scan and a CT scan of her chest, abdomen, and pelvis were normal. Her hematocrit was 25%, with normal electrolytes, and an arterial blood gas analysis showed a pH of 7.30, P_{CO_2} 40 mm Hg, P_{O_2} 90 mm Hg, bicarbonate 22 mEq/L, and base deficit of 6.2. She received 4 units of PRBCs and crystalloid resuscitation. In the operating room, devitalized tissue was debrided from her right upper arm, fixation of her left wrist fracture was performed, and the femur fracture was treated with traction. She was taken to the trauma ICU where resuscitation continued and monitoring was carried out with a PA catheter and arterial line. The patient's initial CO was 2.2 L/min, PCWP 18 mm Hg, and SVO_2 48%. She received an additional 2 units of PRBCs to raise her hematocrit to 35%. Subsequent CO was 3.0 L/min, PCWP 22 mm Hg, SVR 1850, and SVO_2 50%. Sequential attempts at optimizing CO and SVO_2 were made using volume and inotropes. Despite these measures, CO remained fixed. Progressive hypotension ensued, and the patient suffered cardiac arrest 36 hours after admission. Her family requested that she not be resuscitated.

Discussion

The care of the geriatric trauma patient will be more complex in the future as the geriatric population changes. In a study from the Washington Hospital Center group, the elderly have been shown to have a higher mortality rate than that of a younger cohort for all mechanisms of injury, and all levels of injury severity.³ Comparative mortality rates for patients ≥ 65 and < 65 years old for falls was 11.7% vs. 6.0%, motor vehicle crashes 20.7% vs. 9.6%, and pedestrian injuries 32.6% vs. 13.5%. The mortality rate was higher for the ≥ 65 group than for the < 65 group when they were stratified according to their injury severity score (ISS). For example, at the ISS range of 25 to 34 the mortality in the ≥ 65 group was 48% vs. 17.5% for the < 65 group, and for the ISS range of 35 to 44 the mortality was 61.1% vs. 25.8%.

To optimize care of the geriatric trauma patient a number of management principles must be considered. Elderly patients will have decreased physiologic reserve and may have preexisting medical conditions that make their management challenging. To this end, rapid assessment, referral to specialized trauma centers, early invasive hemodynamic monitoring, and vigorous resuscitation can only serve to maximize their initial care. Subsequent attention to potential complications and meticulous supportive care can then improve long-term survival.

The physiologic systems of the elderly often lack adequate reserve to respond to a stressful insult.¹ Atherosclerotic coronary artery disease and changes in pulmonary elasticity associated with aging contribute to loss of cardiac and pulmonary reserve. The decreased ability of the kidneys to handle fluid and electrolyte shifts during resuscitation can compound cardiopulmonary complications. Additionally, elderly patients' medical conditions often require medications that alter physiologic response to injury. For example, the patient in case 1 was found to be taking a beta-blocker for hypertension, inhibiting his ability to mount a tachycardic response to injury. The patient in case 2 had a history of severe congestive heart failure and was found to have a fixed CO despite attempts at manipulating her Frank-Starling curve. An understanding of these altered responses is necessary for proper care of these patients. The elderly patient's prehospital care should include rapid assessment and transport to an appropriate facility. Specialized trauma centers may be uniquely qualified to manage this complicated population.³

Assessment is further complicated by the difficulty in predicting the prognosis of the elderly patient. The Trauma Score (TS) can be used to assess physiologic status. In general, it is useful in determining the need for transfer to a trauma center and in predicting outcome. A higher TS predicts a better prognosis. This correlation, however, is not seen in elderly patients.³ In our case examples, the TS values were high despite both patients having severe injuries usually associated with shock and high mortality. Two major limitations of the TS in evaluating injury severity in the elderly become apparent when the categorization of systolic blood pressure and respiratory rate is reviewed. The systolic blood pressure must fall below 90 before altering the TS. A systolic blood pressure of 90 may not provide adequate perfusion for the elderly patient who may be normally hypertensive. Similarly, a simple measure of the respiratory rate may inadequately predict respiratory failure in the elderly. An alternative predictor, the ISS, has proved to be a reasonable indicator of injury severity and outcome in the older population.³ Unfortunately, complexity in calculating the ISS precludes its use in rapid assessment and triage.

Resuscitation should be carried out using familiar end points of tissue perfusion, such as a resolving base deficit, normalizing lactate acid levels, and SVO_2 . The elderly patient benefits from early hemodynamic monitoring. Scalea et al⁴ compared patients who had "delayed" hemodynamic monitoring with a PA catheter and arterial line (mean time of 5.5 hours from admission) to those treated with "early" monitoring (mean time of 2.2 hours from admission). All patients had hemodynamic status optimized with volume, inotropes, and afterload reduction as needed. Survival in the "delayed" monitored group was 7%, as compared to 53% in those who were monitored "early." Early placement of a PA catheter

and arterial line clearly benefits the elderly patient, who may seem misleadingly stable when vital signs alone are used. The initial case scenario illustrates this phenomenon, as early monitoring revealed evidence of low filling pressures and poor tissue perfusion despite "normal" vital signs. The information obtained from the pulmonary artery catheter significantly altered management, and reduced the time to improve perfusion. On the other hand, the second case was not guided by early hemodynamic monitoring due to a delayed presentation. If early monitoring had been possible, the patient might have benefitted from earlier resuscitation and inotropic support.

Following the resuscitation phase, the elderly patient requires vigorous supportive care. Aggressive measures to prevent avoidable complications may improve survival in elderly trauma victims.⁵ Many studies have shown mortality to be higher in the elderly trauma patient than in a similarly injured younger patient.^{1,3,6,7} The older patient often has longer ICU and hospital lengths of stay and dies "late" from multiple organ dysfunction. In a study by Finelli et al,³ the mean length of stay for the ≥ 65 group was twice that of the < 65 group, 14 vs. 7 days. In another study by Pellicane et al,⁵ preventable complications contributed to 32% of all trauma-related deaths in the elderly, 62% of which were from multiple organ dysfunction. These complications included aspiration of tube feedings, inappropriate extubation, fat embolism, and renal failure. In a study by Smith et al,⁶ mortality in elderly trauma patients was found to correlate directly with the number of complications. With one complication, mortality was 8.6%, and 30% with more than one. Clearly, aggressive efforts to prevent complications are critical.

Prevention of complications begins with early monitoring of hemodynamics and appropriate resuscitation to improve tissue perfusion to decrease the risk of organ failure. Respiratory therapy to reduce pulmonary complications and DVT prophylaxis to reduce the chance of pulmonary embolus should be standard measures. Early fixation of fractures may help reduce the risk of fat embolism and allow early mobilization. Nutritional support, while important, requires careful attention to tube feedings to reduce the risk of aspiration.

The goal of the trauma care provider should be to care for the patient in such a way as to allow maximum recovery. A large number of the geriatric trauma patients who do survive may return to their previous functional level. In a study done at the Mayo Clinic, over 50% of the elderly trauma patients were discharged to home and 75% remained at home at long-term follow-up of 12 months (6-18 months).⁸ The majority of these patients (68%) rated their health as excellent, with 49% back to their normal level of activity.

In summary, to achieve maximum recovery the geriatric trauma patient requires rapid assessment and transport to an appropriate trauma center, followed by aggressive resuscita-

tion with early hemodynamic monitoring to guide therapy. Meticulous attention to details to decrease the complication rates in the geriatric trauma patient may increase survival. Care is at a higher cost in the elderly partially because of longer hospital and ICU lengths of stay. Despite these higher costs, reimbursement has been shown to be inadequate.⁸ Trauma care providers must document the reasons for higher costs of care in the elderly, so that reimbursement can be adjusted and quality of care maintained. □

References

1. Santora TA, Schinco MA, Trooskin SZ: Management of trauma in the elderly patient. *Surg Clin N Am* 74:163-186, 1994.
2. *Current Population Reports, Special Studies, Sixty-Five Plus in America*. US Bureau of the Census, 1992, pp 23-178.
3. Finelli FC, Jonsson J, Champion HR, et al: A case control study for major trauma in geriatric patients. *J Trauma* 29:541-548, 1989.
4. Scalea TM, Simon HM, Duncan AO, et al: Geriatric blunt multiple trauma: improved survival with early invasive monitoring. *J Trauma* 30:129-136, 1990.
5. Pellicane JV, Byrne K, DeMaria EJ: Preventable complications and death from multiple organ failure among geriatric trauma victims. *J Trauma* 33:440-444, 1992.
6. Smith DP, Enderson BL, Maull KI: Trauma in the elderly: determinants of outcome. *South Med J* 83:171-177, 1990.
7. Osler T, Hales K, Baack B, et al: Trauma in the elderly. *Am J Surg* 156:537-543, 1988.
8. Zietlow SP, Capizzi PJ, Bannon MP, et al: Multisystem geriatric trauma. *J Trauma* 37:985-988, 1994.

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Vanderbilt Morning Report

A Potentially Fatal Drug Reaction

Case Report

A 50-year-old black man with a history of complex partial seizures since childhood, hypothyroidism, and ulcerative colitis presented himself to the Vanderbilt Primary Care Medicine Clinic complaining of fever, rash, nausea, and anorexia. His seizure disorder had been well-controlled with phenobarbital and phenytoin until 18 months ago, when these were discontinued and carbamazepine was started because of breakthrough seizures. After several months, the patient developed pancytopenia and an exfoliative dermatitis that resolved after carbamazepine was discontinued. Valproic acid was then prescribed, but it was discontinued six weeks before his current presentation because of poor seizure control, and phenytoin was reinstituted. Three weeks later, he noted patches of non-tender, non-pruritic erythema on his upper and lower extremities distally, which gradually progressed proximally. A serum phenytoin level one week before his clinic visit was 39.5 µg/ml, so that administration of the drug was suspended. He developed daily fevers to 103°F, nausea, decreased appetite, and dark urine over the three days prior to his clinic visit. His other medications included levothyroxine and acetaminophen, which he was taking at a dose of about 2 gm/day. He denied use of alcohol or illicit drugs.

His temperature was 100.6°F, blood pressure 130/76 mm Hg, heart rate 140/min, and respiratory rate 18/min. His mucous membranes were dry and skin turgor was poor. His sclerae were anicteric. There was diffuse, non-tender erythroderma involving the arms, legs and trunk, with desquamation of the palms, soles and lips, and numerous 4-mm white vesicles over the involved areas. There was moderate periorbital and perioral edema. Lungs were clear to auscultation and heart sounds were regular and tachycardic without murmur. His abdomen was soft, with mild right upper quadrant tenderness. The liver edge was not palpable. Shotty inguinal adenopathy was present bilaterally.

Laboratory evaluation revealed a WBC count of 12,700/cu mm, with 9% eosinophils, 13% atypical lymphocytes, and a hematocrit of 37%. Total bilirubin was 3.5 mg/dl, SGOT 49 IU/L, alkaline phosphatase 418 IU/L, albumin 3.1 gm/dl and prothrombin time 15 seconds, with INR of 1.3. Despite discontinuation of the drug six days earlier, a serum phenytoin

level was 15.4 µg/ml. A skin biopsy revealed a superficial dermal lichenoid inflammatory infiltrate with many eosinophils. He was admitted to the hospital for intravenous fluid resuscitation and skin care. Cultures of the blood, urine, and sputum showed no growth. Over the subsequent two weeks he had progression of his skin and liver injury, and he continues to receive in-hospital supportive care at this writing.

Discussion

Phenytoin hypersensitivity syndrome is a potentially lethal drug side effect that has been estimated to occur once in 1,000 to 10,000 exposures.¹ The phenytoin syndrome was first described in a case report by Chaiken and colleagues² in 1950. Today, the preferred term for this entity is anticonvulsant hypersensitivity syndrome (AHS), as it has been recognized that other arene oxide-producing anticonvulsants such as carbamazepine and phenobarbital can also produce the characteristic signs and symptoms.

The triad of fever, rash, and adenopathy during anticonvulsant use should raise clinical suspicion of the diagnosis. Fever is almost always present, and may persist for several weeks after discontinuation of the medication. Hepatitis, hematologic abnormalities (leukocytosis with atypical lymphocytes, eosinophilia, or Coombs-negative hemolytic anemia), or multiorgan-system involvement have been reported in 50% to 60% of cases.¹ Periorbital edema, arthralgia, myalgia, and pharyngitis can be seen less frequently, and interstitial pneumonitis, interstitial nephritis, and rhabdomyolysis have also been reported. Onset of symptoms typically occurs within 90 days of initiating therapy, most often in the first month.

The rash typically begins as patchy areas of erythema that become pruritic and can coalesce into an exfoliative erythroderma. Sterile pustule formation may follow, and desquamation occurs as the rash resolves. Skin biopsy usually reveals a dense, superficial, perivascular lymphocytic infiltrate with varying degrees of edema. Erythema multiforme and toxic epidermal necrolysis are uncommon, but may occur. The rash is often accompanied by localized or generalized lymphadenopathy. Although benign lymphoid hyperplasia is usually found histologically, atypical hyperplasia with loss of normal nodal architecture and abnormal cells with frequent mitotic figures can be seen. It is termed pseudolymphoma, and resolves following discontinuation of the drug.³

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There does not appear to be an age or gender predilection for development of AHS, although the incidence of severe reactions is highest in elderly black men. Fatal outcomes are most often associated with hepatic failure, as overall mortality is 18% to 40% when the liver is involved.¹ Inadvertent drug rechallenge in patients with phenytoin hepatitis is often lethal.

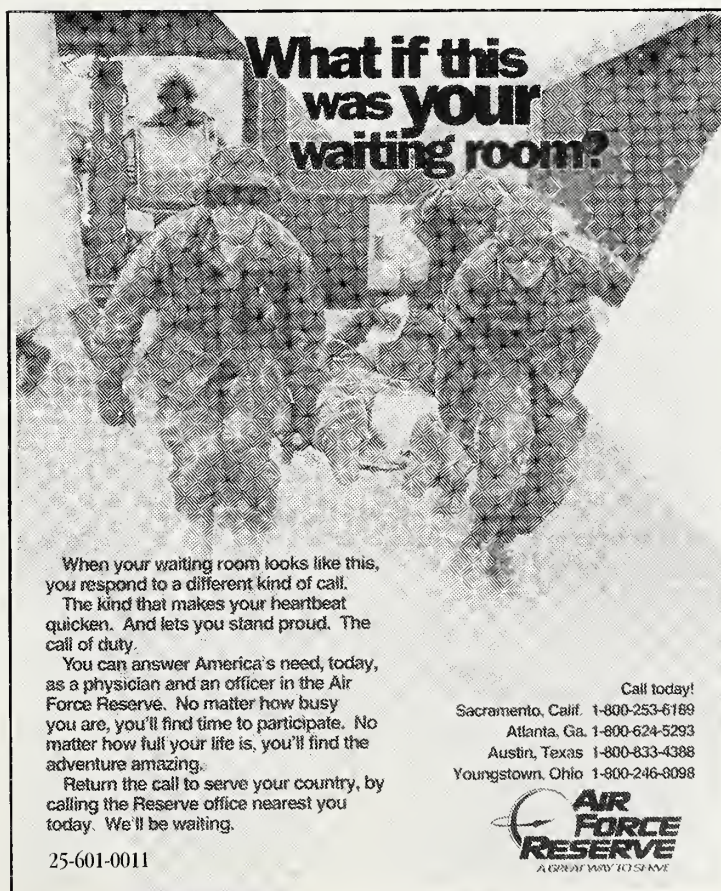
The pathophysiology behind AHS remains unclear. Evidence suggesting the role of an allergic hypersensitivity reaction includes the need for an induction period after initial exposure but not on rechallenge, as well as the lack of a linear relationship between dosage or serum levels and symptom development.³ Circulating anti-phenytoin antibodies have been identified in some patients, but their role in the syndrome is not established. Alteration of lymphocyte "self" recognition due to the binding of phenytoin has also been implicated. Epoxide hydrolase is an enzyme that detoxifies arene oxides produced by the metabolism of phenytoin, carbamazepine, and phenobarbital, and work by Spielberg and colleagues⁴ suggests that a mutation in the gene encoding this protein may be responsible for development of the syn-

drome. In-vitro testing by the same group suggests that siblings of patients with AHS are also at increased risk for the disorder.

Recognition of the syndrome and prompt discontinuation of the suspected drug are essential. Arene oxide-producing anticonvulsants should be avoided in these patients. Valproic acid is an acceptable alternative, although its hepatic metabolism limits its use in the acute or convalescent phase of the illness. Gabapentin or lamotrigine may be useful drugs for seizure control in AHS patients, and clinical trials of their use as monotherapy are underway. Supportive care is the cornerstone of therapy for AHS, and includes fluid resuscitation, topical corticosteroids, and skin care. Systemic corticosteroids do not seem to improve overall outcome.¹ □

References

1. Vittorio CC, Muglia JJ: Anticonvulsant hypersensitivity syndrome. *Arch Intern Med* 155:2285-2290, 1995.
2. Chaiken BH, Goldberg BI, Segal JP: Dilantin hypersensitivity: report of a case of hepatitis with jaundice, pyrexia, and exfoliative dermatitis. *N Engl J Med* 242:897-898, 1950.
3. Silverman AK, Fairley J, Wong RC: Cutaneous and immunologic reactions to phenytoin. *J Am Acad Dermatol* 18:721-741, 1988.
4. Spielberg SP, Gordon GB, Blake DA, et al: Predisposition to phenytoin hepatotoxicity assessed in vitro. *N Engl J Med* 305:722-727, 1981.



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Preventive Medicine Series

Avoiding Problems Prescribing to Older Patients

Rebecca J. Beyth, MD and Ronald I. Shorr, MD, MS

Although persons aged 65 and older comprise only 12% of the United States population, they are the recipients of one-third of all prescription drugs and take more than one-half of all over-the-counter medicines.^{1,2} More than 80% of all older people take at least one medication daily. With the increasing number of patients surviving to older ages and accounting for such a large proportion of drug use, health care providers need an understanding of the risks, benefits, and consequences of drug therapy in older patients. In this review, we will focus on giving practical suggestions for prescribing drugs for the older patient.

Clinical Pharmacology

The physiologic changes that accompany aging affect the pharmacologic processes of distribution, metabolism, and excretion. The absorption of drugs, which occurs mainly by passive diffusion, is altered more by concomitant administration of other medications than by physiologic changes related to aging. For example, antacids decrease the oral absorption of cimetidine, and alcohol accelerates the absorption of chloral hydrate.

Distribution. Age affects drug distribution in several clinically important ways. For example, the relative increase in body fat and the decrease in lean body mass associated with aging causes fat-soluble drugs to be distributed more widely and water-soluble drugs less widely³ (Table 1). The increased distribution of fat-soluble drugs can delay elimination and may cause a prolonged duration of action of a single dose. This is especially important for drugs such as hypnotics and analgesics, which are given in intermittent single doses. For example, the volume of distribution of diazepam is increased almost two-fold in older patients, and its elimination half-life is prolonged from 24 hours in young patients to approximately 90 hours in older patients. In contrast, the volume of distribution of water-soluble compounds such as digoxin is decreased in older patients, thereby lowering the dose required

to reach a target plasma concentration. The decreased volume of distribution also lowers the loading dose of aminoglycosides for older patients.

Protein Binding. For drugs that bind to serum proteins, there is an equilibrium between the bound (or ineffective) proportion and the unbound (or effective) proportion. For acidic drugs that are highly bound to albumin, the free plasma concentrations may correlate best with pharmacologic effect. Although albumin levels decrease only slightly with age, they do tend to decrease during periods of illnesses.⁴ This can result in elevated levels of free drugs for older persons during episodes of illness with an increased potential for toxicity. These changes can be significant for drugs such as thyroid hormone, digoxin, warfarin, and phenytoin.

Metabolism. The liver is the primary site of drug metabolism. There is significant decline in liver blood flow with age, with reductions of 25% to 47% reported in persons between the ages of 25 and 90.⁵ This decrease in hepatic blood flow is clinically important because hepatic metabolism is the rate-limiting step that determines the clearance of most metabolized drugs. This is especially relevant for drugs that undergo rapid hepatic metabolism (e.g., propranolol). Also, drugs that undergo extensive first-pass metabolism are likely to reach higher blood levels when hepatic blood flow is decreased.

The liver metabolizes drugs through two distinct systems. Phase I metabolism involves drug oxidation and reduction and is catalyzed primarily by the cytochrome P450 system in the smooth endoplasmic reticulum of hepatocytes. Phase I metabolism undergoes a substantial decrease in activity with age. Drugs that are metabolized through phase I enzymatic

TABLE 1
VOLUME OF DISTRIBUTION OF COMMONLY PRESCRIBED DRUGS

Increased Volume	Decreased Volume*
Acetaminophen	Cimetidine
Chlordiazepoxide	Digoxin
Diazepam	Ethanol
Oxazepam	Gentamicin
Prazosin	Meperidine
Salicylates	Phenytoin
Thiopental	Quinine
Tolbutamide	Theophylline

*If the volume of distribution is decreased, drug levels tend to be higher.

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TABLE 2
COMMONLY PRESCRIBED DRUGS WITH PROLONGED
HEPATIC METABOLISM IN THE ELDERLY

Acetaminophen	Diphenhydramine	Meperidine	Quinidine
Amitriptyline	Flurazepam	Nortriptyline	Salicylates
Barbiturates	Ibuprofen	Phenytoin	Theophylline
Chlordiazepoxide	Labetalol	Prazosin	Tolbutamide
Diazepam	Lidocaine	Propranolol	Warfarin

activity will have prolonged half-lives (Table 2). Phase II hepatic metabolism involves the conjugation of drugs or their metabolites to organic substrates. The elimination of drugs that undergo phase II metabolism by conjugation (e.g., acetylation, glucouronidation, sulfation, and glycine conjugation) is generally altered less with age. Thus, drugs that require only phase II metabolism for excretion (e.g., triazolam) do not have a prolonged half-life in older people. Other drugs such as diazepam undergo both phases of metabolism and have intermediately active metabolites.

Excretion. Drug excretion is usually mediated by the kidney. Renal function, as estimated by creatinine clearance, declines by 50% from age 25 to 85, even though serum creatinine levels remain unchanged. As a result, the half-life of renally excreted drugs is prolonged and serum levels of these agents are increased. For drugs with large therapeutic indices (e.g., penicillin), this is of little clinical importance; for drugs with a narrower therapeutic index (e.g., digoxin, cimetidine, aminoglycosides), however, side effects may occur in older patients if the dose is not reduced. Thus, it is not surprising that digoxin is the drug that most often causes side effects in the elderly, especially when doses exceed 0.125 mg daily.^{6,7} To further define dose requirements, drugs with a low therapeutic index should be monitored.

Pharmacodynamics. In addition to the factors that determine the drug concentration at the site of action (pharmacokinetics), the effect of a drug also depends on the target organ sensitivity to the drug (pharmacodynamics). Pharmacodynamics have been less extensively studied than pharmacokinetics in older patients. Older patients seem to be more sensitive to the sedative effects of given blood levels of benzodiazepine drugs (e.g., diazepam)⁸ and less sensitive to the effects of drugs that are mediated by beta-adrenergic receptors (e.g., isoproterenol, propranolol).⁹ Although there is a suspected

TABLE 3
EXAMPLES OF ADVERSE DRUG REACTIONS

Type of Drug	Common Adverse Reaction
Narcotics	Constipation
Aminoglycosides	Renal failure, hearing loss
Anticholinergics	Dry mouth, constipation, urinary retention, delirium
Antiarrhythmics	Diarrhea (quinidine); urinary retention (disopyramide)
Diuretics	Dehydration, hyponatremia, hypokalemia, incontinence
Antipsychotics	Delirium, sedation, hypotension, extrapyramidal movement disorders
Sedative-hypnotics	Excessive sedation, delirium, gait disturbances

age-related decline in hormone receptor affinity or number (e.g., beta-adrenergic receptors), definitive data demonstrating such an alteration are sparse. Other possible explanations offered for these differences are alterations in second messenger function, as well as cellular and nuclear responses.

Therapeutic Risks: Special Considerations in the Elderly

Compliance. Noncompliance with drug therapy is reported to occur in one-third to one-half of older patients.¹⁰ Approximately one in five prescriptions is not filled, and between one-third and two-thirds of patients who do fill prescriptions do not use the medications as intended by the physician.¹¹ Noncompliance may occur anywhere along the continuum from prescription (e.g., inability to pay for medications, lack of trust in the physician or treatment plan) to administration (e.g., inability to open container), but the most important predictor of noncompliance is the number of medications prescribed. Older patients can have adherence rates as high as 80% to 90% if they are given clear written and verbal instructions, a simple dosing schedule, and fewer medications.¹² Serious complications can arise when the prescriber incorrectly assumes that patients have been compliant with therapy. When medication appears to be ineffective, prescribers often increase the dose of a medication or prescribe a more powerful drug. A change in circumstance, such as increased supervision from home nursing, family, or hospitalization, can then lead to toxicity.

Knowledge Base of Safety and Efficacy. Drug therapy in the elderly is complicated by many factors that are unique to this age group. Multiple comorbid conditions, environmental conditions, genetic variation, and the physiologic effects of aging all interact to affect drug disposition in the elderly. Although the judicious use of medications can profoundly reduce the mortality and morbidity of many diseases of the elderly, the appropriate use of medications is hampered by the lack of data. There have been little data on how age affects the sites of drug action. Likewise, there is insufficient information about drug disposition and response in the very old, i.e., those over 85 years of age. Although older patients are often the intended targets of new drugs, they are usually not recruited to participate in clinical drug trials. As a result, extrapolations on dosage and possible side effects may or may not be accurate or appropriate.

Adverse Drug Reactions. A recent analysis¹³ estimated that drug-related morbidity and mortality cost \$76.6 billion in the United States, with the largest component of this total cost being drug-related hospitalizations. The incidence of adverse drug reactions in hospitalized patients increases from about 10% in 40- to 50-year-old patients, to 25% in patients older than 80 years of age.^{14,15} In 1986, 51% of deaths due to adverse drug reactions occurred in elderly patients. Reported rates of drug-related hospital admissions have ranged from

2.3% to 27.3%.¹⁶ Many drugs prescribed for older patients have the potential to cause life-threatening or disabling adverse reactions (Table 3). Cardiovascular and psychotropic drugs are the most common causes of serious adverse reactions in the elderly. These reactions result from a combination of a narrow therapeutic-toxic window, age-related changes such as reduced renal excretion, and prolonged duration of action—all of which predispose the older patient to adverse reactions. Adverse drug reactions are often not recognized because the symptoms are nonspecific or mimic other illnesses. Often another drug is prescribed to treat these symptoms, resulting in polypharmacy and increasing the likelihood of an adverse drug reaction.

Prescribing in the Nursing Home

Residents in nursing homes, the frailest of all the elderly, are prescribed more medications than their noninstitutionalized peers.^{2,17} Nursing home residents are also more vulnerable because frailty and dementia may preclude their participation in decisions about medical therapy. Thus, the complex medical conditions and institutional environment of this patient population puts it at greatly increased risk for adverse drug reactions and polypharmacy. Also, sufficient data to determine the appropriate use of medications in these institutionalized persons, as well as the risks vs. the benefits of therapy, are lacking.

More recently, federal legislation has limited the use of psychoactive drugs in nursing home residents. The Nursing Home Reform Amendments of the Omnibus Budget Reconciliation Act (OBRA '87) require the regulation of the use of psychoactive medication in Medicare- and Medicaid-certified nursing homes. Explicit documentation in the medical record must justify the need, and close monitoring and periodic withdrawal of antipsychotic medications are required.^{18,19} Guidelines were developed and implemented for antipsychotics, anxiolytics, and sedatives. Although these recent regulatory changes have had some impact,²⁰ many studies indicate that about 50% of all nursing home residents are prescribed one or more psychoactive drugs.^{21,22} Despite limited data to support its effectiveness, antipsychotic medication is often used in the treatment of agitation in older dementia patients.²³ These drugs are known to be associated with extrapyramidal symptoms, gait instability, falls, and hip fractures.^{24,25} Likewise, the use of benzodiazepines to treat agitation, especially those with a long elimination half-life, is associated with falls, fractures, daytime somnolence, confusion, and ataxia.²⁶⁻²⁸

Nonpharmacologic interventions may often be as effective as drugs in managing some of the behavior seen in elderly nursing home residents.²⁹⁻³¹ Examples include increased tolerance from staff members for repetitious requests, especially designed facilities to accommodate freedom of movement and supervision, personal attention and support, avoidance of caffeine at night, regular exercise, and later bedtimes.

Conclusion

It is important for health care providers to be aware of the issues involved in using drug therapy in older patients because older patients are the ones most vulnerable to the adverse effects of drugs. Although more data are needed to guide clinical decision-making in prescribing drugs to older patients, some simple considerations can make drug use safer and more effective: (1) Define the illness and treatment goals. (2) Assure compliance or adherence before adding or changing medications. (3) Have a low threshold of suspicion for drug side effects. (4) *Primum non nocere* (first do no harm). Careful, compassionate attention to these factors can have a profound effect on improving the quality of life, medication use, and the overall cost of health care in this vulnerable population. □

References

- Koch H, Knap DA: *Highlights of Drug Utilization in Office Practice: National Ambulatory Medical Care Survey*, 1985. Rockville, MD, National Center for Health Statistics, 1987.
- Ostrom JF, Hammarlund ER, Christensen DB, et al: Medication usage in an elderly population. *Med Care* 23:157, 1985.
- Vestal RE, Dawson GW: *Handbook of the Biology of Aging*, ed 2. New York, Van Nostrand Reinhold, 1985, p 744.
- Woodford-Williams E, Alvarez AS, Webster D, et al: Serum protein patterns in "normal" and pathological aging. *Gerontologia* 10:86, 1964.
- Wynne HA, Cope LH, Mutch E, et al: The effect of age upon liver volume and apparent liver blood flow in healthy men. *Hepatology* 9:297, 1989.
- Nolan L, O'Malley K: Prescribing for the elderly: Part I. Sensitivity of the elderly to adverse drug reactions. *J Am Geriatr Soc* 36:142, 1988.
- Williamson J, Chopin JM: Adverse reactions to prescribed drugs in the elderly: a multicenter investigation. *Age Aging* 9:73, 1980.
- Greenblatt DJ, Divoll M, Harmatz JS, et al: Kinetics and clinical effects of flurazepam in young and elderly noninsomniacs. *Clin Pharmacol Ther* 30:475, 1979.
- Vestal RE, Wood AJ, Shand DG: Reduced beta-adrenergic sensitivity in the elderly. *Clin Pharmacol Ther* 26:181, 1979.
- Morrow D, Leirer V, Sheikh J: Adherence and medication instructions: review and recommendations. *J Am Geriatr Soc* 36:1147, 1988.
- Stewart RB, Cluff LE: A review of medication errors and compliance in ambulant patients. *Clin Pharmacol Ther* 13:463, 1972.
- Black DM, Brand RJ, Greenlick M, et al: Compliance to treatment for hypertension in elderly patients: the SHEP pilot study. *J Gerontol* 43:552, 1987.
- Johnson JA, Bootman JL: Drug-related morbidity and mortality: a cost-of-illness model. *Arch Intern Med* 155:1949, 1995.
- Seidl LG, Thornton GF, Smith JW, et al: Studies on the epidemiology of adverse drug reactions: III. Reactions in patients on a general medical service. *Bull Johns Hopkins Hosp* 119:299, 1966.
- Hurwitz N: Predisposing factors in adverse reactions to drugs. *Br Med J* 1:536, 1969.
- McKenney JM, Harrison WL: Drug-related hospital admissions. *Am J Hosp Pharm* 33:792, 1976.
- Chrischilles EA, Foley DJ, Wallace RB, et al: Use of medications by persons 65 and over; data from the established populations for epidemiologic studies of the elderly. *J Gerontol* 47:137, 1992.
- Winograd CH, Pawlson LG: OBRA 87 - a commentary. *J Am Geriatr Soc* 39:724, 1991.
- Elon R, Pawlson LG: The impact of OBRA on medical practice within nursing facilities. *J Am Geriatr Soc* 40:958, 1992.
- Shorr RI, Fought RL, Ray WA: Changes in antipsychotic drug use in nursing homes during implementation of OBRA '87 regulations. *JAMA* 271:358, 1994.
- Beers M, Avorn J, Soumerai SB, et al: Psychoactive medication use in intermediate-care facility residents. *JAMA* 260:3016, 1988.
- Beers MH, Ouslander JG, Rollinger I, et al: Explicit criteria for determining inappropriate medication use in nursing home residents. *Arch Intern Med* 151:1825, 1991.
- Schneider LS, Pollock VE, Lyness SA: A metaanalysis of controlled trials of neuroleptic treatment in dementia. *J Am Geriatr Soc* 35:553, 1990.
- Ray WA, Griffin MR, Schaffer W, et al: Psychotropic drug use and the risk of hip fracture. *N Engl J Med* 316:363, 1987.
- Avorn J, Monane M, Everitt DE, et al: Clinical assessment of extrapyramidal signs in nursing home patients given antipsychotic medication. *Arch Intern Med* 154:1113, 1994.
- Ray WA, Griffin MR, Downey W: Benzodiazepines of long and short elimination half-life and the risk of hip fracture. *JAMA* 262:3303, 1989.
- Cummings SR, Nevitt MC, Browner WS, et al: Risk factors for hip fracture in white women. Study of Osteoporotic Fractures Research Group. *N Engl J Med* 332:767, 1995.
- Greenblatt D, Allen MD, Shader RI: Toxicity of high-dose flurazepam in the elderly. *Clin Pharmacol Ther* 21:355, 1977.
- Everitt DE, Fields DR, Soumerai SS, et al: Resident behavior and staff distress in the nursing home. *J Am Geriatr Soc* 39:792, 1991.
- Avorn J, Gurwitz JH: Drug use in the nursing home. *Ann Intern Med* 123:195, 1995.
- Avorn J, Soumerai SB, Everitt DE, et al: A randomized trial of a program to reduce the use of psychoactive drugs in nursing homes. *N Engl J Med* 327:168, 1992.

*Department of Health Report***Tobacco Use: Tennessee Youths at Risk**

Cornelia M. Pearson, RN, MN

As the leading cause of preventable disease and premature death in the United States, tobacco use is a major public health problem. Although the epidemic of disease and death from smoking is played out in adulthood, it begins in childhood. Each day 3,000 young people, an estimated 60 of whom are Tennesseans, become regular smokers. One out of three youths who become addicted to nicotine will eventually die as a result of their smoking habit.¹

The average teenage smoker starts smoking at 14½ years and becomes a daily smoker before age 18. According to the Centers for Disease Control and Prevention's (CDC) Youth Risk Behavior Survey, Tennessee's teen smoking initiation rate is no exception. Of those Tennessee high school students surveyed, the majority smoked their first cigarette at age 14 or below. Of these students, 10% to 13% smoked their first whole cigarette before the age of 9 years. Smoking initiation at a young age increases the risk of severe nicotine addiction and subsequent heavy smoking.

Teens who smoke are three times more likely than non-smokers to use alcohol, eight times more likely to use marijuana, and 22 times more likely to use cocaine. In fact, several studies have shown that cigarette smoking and alcohol use generally precede marijuana smoking and other illegal drug use. Teen smokeless tobacco users are more likely than nonusers to become cigarette smokers. Smoking is also associated with other risky behavior such as carrying weapons and engaging in higher-risk sexual behavior.²

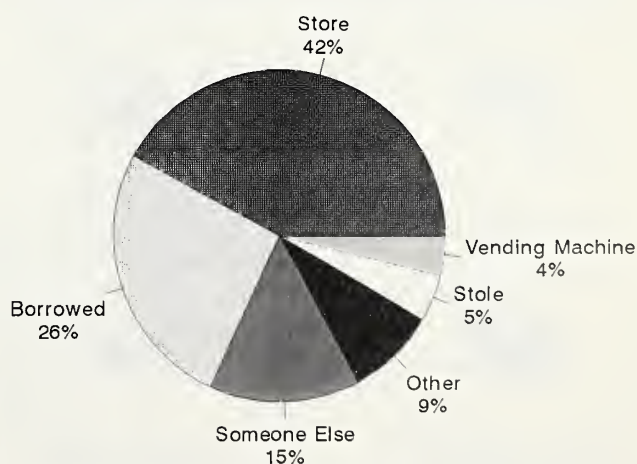
Adolescents tend to greatly underestimate the likelihood that they will become addicted to tobacco products. While only 5% of daily smokers surveyed in high school said they would definitely be smoking five years later, close to 75% were smoking seven to nine years later. A 1992 survey found that approximately two out of three youths who smoked said they wanted to quit and 70% said they would not start smoking if they could have a second chance to make that choice.³

It is difficult for youths to see the long-term relationship between tobacco use and its health consequences. Youths who smoke are most often already at risk due to low socioeconomic status, lack of parental guidance, low level of academic achievement and school involvement, low self-esteem,

and lack of self-sufficiency. The psychosocial risk factors for the initiation of tobacco use among children and adolescents coupled with societal complacency regarding tobacco use by youths continues to lead to the premature death of more than 400,000 Americans each year. In Tennessee, more than 10,000 adults die each year from smoking-related illnesses. For each of these deaths, an average of 13 years of potential life is lost. The cost of direct medical care related to smoking in 1990 in Tennessee was greater than \$782 million, a large price to pay for preventable illnesses that include cancer, heart, and respiratory diseases.⁴

In 1994, the Tennessee Legislature passed legislation strengthening Tennessee's youth access law. Businesses that sell cigarettes to minors are inspected to assure that single cigarettes are no longer sold over the counter, that signs are visible stating that it is illegal to sell tobacco to minors, and vending machines are placed so that they are supervised at all times or accessible only by token. Based on national figures, it is estimated that in spite of Tennessee's law, Tennessee children under 18 years of age consume at least 18 million packs of cigarettes and at least one-half million containers of spit tobacco yearly. According to data from CDC, cigarette smoking among youths in Tennessee is close to 9%

FIGURE 1
Cigarette Source
High School Students Who Obtained Cigarettes



Unweighted Data. Source: 1995 TN YRBS

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higher than cigarette smoking among adults. The data also show that the youth smoking rate in Tennessee is exceeded by only three of the 30 states surveyed.

The 1995 Tennessee Youth Risk Behavior Survey data (Fig. 1) show that more than 45% of high school students who smoke in Tennessee are purchasing cigarettes either across the counter from retail merchants or from vending machines. Fig. 2 shows how easy it is for high school students to purchase cigarettes without being questioned about age. Almost 70% of respondents who use cigarettes were able to purchase them without being asked for proof of age. Younger teens were asked for proof of age less often than youths 18 years of age or older.

After reviewing the current data on youth tobacco use behavior, it becomes obvious that Tennessee will not reach the national Healthy People 2000 goal for youth tobacco use anytime in the near future. This goal states that the nation will reduce the initiation of cigarette smoking by children and youths so that no more than 15% have become regular cigarette smokers by age 20.⁵ If we are to reach this goal, even within the next ten years, significant action must be taken by stakeholders across the state.

A plethora of resources is available to assist communities in initiating youth access prevention activities. Many of these are free and easy to access. Some new resources that are being utilized in Tennessee are listed below:

- A 26-minute video entitled "Stop the Sale, Prevent the Addiction," was released early in 1996 by CDC's Office on Smoking and Health. The video underscores the magnitude of the problem of youth tobacco use by highlighting some of the influences that lead youths to use tobacco. It also features programs that are working to prevent tobacco sales to minors. A facilitator's guide accompanies the video. A copy of the "Stop the Sale" material has been distributed to Par-

ent-Teachers Association chapters across the state.

- The "Performance Edge," also produced by the Office on Smoking and Health, asks young people to say "yes" to peak performance—in sports, in class, and in life—and explains how tobacco, alcohol, and other drugs can negatively affect the things that youths love. This package includes a fast-paced, MTV-style video, a 14-page magazine, and a leader's guide. Every public school in Tennessee with grades 6 through 12 has received a copy of the "Performance Edge."

- The Tennessee Department of Health has recently completed a "Youth Tobacco Use Prevention Guide for Retailers." This kit is designed to educate retailers about their responsibility in reducing the sale of tobacco products to minors. Materials include a 10-minute video highlighting strategies for refusing to sell tobacco products to minors and written guidelines for training retail employees to become partners in the youth sales prevention process. Retail education kits will be distributed to tobacco retailers during the spring of 1996.

In addition to resource materials, the Tennessee Department of Health supports the activities of the Tennessee Action Coalition on Tobacco (TACT). Organized in November 1994, TACT is composed of a diverse group of individuals including representation from schools, voluntary and non-profit organizations, business, industry, health care professions, consumers, and minority groups. The mission of TACT is to promote programs and strategies that assist Tennesseans to reduce the adverse impact of tobacco. TACT has designated 1996 as the "Year of Youth Access Prevention in Tennessee," and is focusing on strategies to inform the public of the seriousness of the youth tobacco use problem.

There is no "quick fix" for this public health problem. Even with innovative educational strategies, youths will continue to use tobacco products as long as they are easily accessible. Tennessee youths deserve a lifetime free of tobacco addiction. For them to succeed, it is imperative that communities find innovative ways to help them resist the pressure to use tobacco. Youths must also receive the strong message during the early, impressionable years that tobacco use is addictive and has long-term health consequences.

For more information on available resources or how to participate in TACT, call 1-800-293-TACT. □

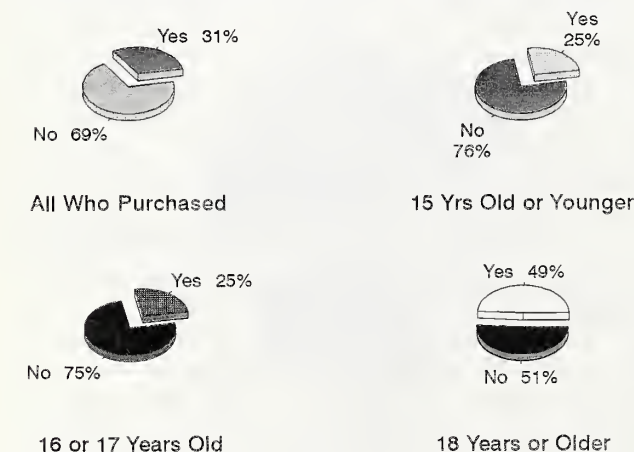
Acknowledgments: The figures were prepared by Marilyn Ontiveros, RNC, MN, Director, School Health Program, Maternal and Child Health Services, Tennessee Department of Health.

References

1. *Information Resource and Referral Guide, Restricting Access and Appeal of Tobacco Products to Children and Adolescents.* Atlanta, U.S. Department of Health and Human Services, Office on Smoking and Health, Centers for Disease Control and Prevention, October, 1995.
2. *Teens and Tobacco, Facts not Fictions.* Atlanta, U.S. Department of Health and Human Services, Office on Smoking and Health, Centers for Disease Control and Prevention, 1995.
3. *Preventing Tobacco Use Among Young People: A Report of the Surgeon General.* PHS Publication No. 017-001-00491-0. U.S. Department of Health and Human Services, 1994.
4. *State Tobacco Control Highlights 1996.* CDC Publication No. 099-4895. Atlanta, U.S. Department of Health and Human Services, Office on Smoking and Health, Centers for Disease Control and Prevention, 1996.
5. *Healthy People 2000 - National Health Promotion and Disease Prevention Objectives.* DHHS Publication No. (PHS) 91-50213. U.S. Department of Health and Human Services, September, 1990.

FIGURE 2

Students Asked for Proof of Age When Purchasing Cigarettes in a Store—Past 30 Days



Unweighted Data. Source: 1995 TN YRBS

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TMA Alliance Report

Handrails for Membership

Our theme across Tennessee this year is "Handrails for Membership." They are as follows:

- We can *renew* the present members—by never failing to recognize them for their continued support of the Alliance, by always keeping them up to date on the ever-changing health care issues and how we are in this together!

- We can *recruit* new members—they are tomorrow's leaders, nurture them and watch them grow!

- We can *reactivate* the old members—by telling about the excellent benefits of belonging to the Alliance and how we need their support—capitalize on their qualifications!

- We can *regain* the drop-out members—by telling them how very much they are missed. Explain the issues of current legislation and how important it would be to their spouses' profession if they took part in the Alliance.

- We can *reach* out and grow—by talking to the resident physician and medical students' spouses. Ask them to come and join us at one of our meetings and they will see for themselves how easily they can find their area of expertise.

- We can *retain* members—we strive for the same goals, "Physicians' spouses dedicated to the health of America."

These are "Handrails for Membership." It is up to us to put them to work.

Society has dictated the current trend of membership in organizations across the country. The current term, "downsizing" is only elective in volunteer groups. We are not the only organization feeling the membership crunch.

We must turn that into a plus-positive by making our organization the one organization that the physician's spouse wants to be a part of!

Peggy Larkin
State Membership Chairman

In Memoriam

David L. McCroskey, age 64. Died June 12, 1996. Graduate of Vanderbilt University School of Medicine. Member of Blount County Medical Society.

William M. Tipton, age 82. Died May 18, 1996. Graduate of University of Tennessee College of Medicine. Member of Knoxville Academy of Medicine.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

BRADLEY COUNTY MEDICAL SOCIETY

Robert H. Cofer, MD, Cleveland

NASHVILLE ACADEMY OF MEDICINE

Lawrence A. Klinsky, MD, Antioch

Susan E. Mackey, MD, Nashville

William L. Moore Jr., MD, Hendersonville

Nancy W. Peacock, MD, Nashville

Catherine M. Thornburg, MD, Nashville

GREENE COUNTY MEDICAL SOCIETY

Philip T. Thwing, MD, Greeneville

KNOXVILLE ACADEMY OF MEDICINE

Fred M. Furr, MD, Knoxville

David A. Martin, MD, Knoxville

Gregory L. Phelps, MD, Knoxville

OVERTON COUNTY MEDICAL SOCIETY

Nancy Y. Blevins, MD, Livingston

SUMNER COUNTY MEDICAL SOCIETY

Timothy R. Bastin, MD, Gallatin

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during May, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Irshad A. Ahmad, MD, Johnson City
George F. Bale, MD, Memphis
B. Daniel Beaver, MD, Portland
Michael T. Beckham, MD, Nashville
Ziad Blaik, MD, Johnson City
Mark W. Bookout, MD, Chattanooga
James W. Bryant, MD, Memphis
Cathy M. Chapman, MD, Cordova
Lawrence L. Cohen, MD, Memphis
Tommy H. Crunk, MD, Springfield
Mary S. David, MD, Dyersburg

Webb J. Earthman, MD, Nashville
Stuart A. Frank, MD, Chattanooga
Thaddeus B. Gaillard, MD, Germantown
Michael E. Glasscock, MD, Nashville
James A. Greene, MD, Knoxville
James M. Hudgins, MD, Hendersonville
John G. Huff, MD, Nashville
Stephen M. Kimbrough, MD, Johnson City
Albert J. Mitchum, MD, Clarksville
Vernon T. Morehead, MD, Nashville
Robert L. Naderthal, MD, Nashville

Roger T. Nelson, MD, Wildwood, GA
Henry C. Newsome, MD, Nashville
Richard A. Obenour, MD, Knoxville
Stanley M. Patterson, MD, Memphis
Frederick S. Rayne, MD, Cookeville
Harold P. Smith, MD, Nashville
Brian R. Swenson, MD, Nashville
Michael C. Trotter, MD, Memphis
David B. Welch, MD, Johnson City
Lester F. Williams, MD, Nashville
Charles J. Woodall, MD, Memphis

Personal News

McCarthy DeMere, MD, Collierville, a licensed physician and attorney, has been elected chancellor general of the National Society of the Sons of the American Revolution, the highest legal position in the society.

G. Keith Lovelady, MD, Manchester, has been certified as a Diplomate in critical care medicine by the American Board of Internal Medicine.

Board of Medical Examiners

Minutes - May, 1996

Name: Camran G. Adly, MD (Lafayette, LA)

Violation: Disciplinary action taken by another state.

Action: License suspended; assessed civil penalty of \$100.

Name: James P. Gregory II, MD (Nashville)

Violation: Unprofessional, dishonorable, or unethical conduct; failure to maintain adequate records of controlled substances; improper prescribing of controlled substances that were not medically justified and in excessive doses; prescribing controlled substances to an addicted person without making a bona fide effort to cure his habit.

Action: Per agreed order, license placed on probation for two years; may not prescribe, administer, dispense, order, or possess Schedule II controlled substances; assessed civil penalties totaling \$3,750; must complete additional continuing medical education in addictionology, pharmacology, and chronic pain management; reprimanded.

Name: Mark Grimsley, MD (Chattanooga)

Violation: Conviction of a felony; unprofessional, dishonorable, or unethical conduct.

Action: Per agreed order, license revoked; may not reapply for licensure under any circumstances until released from prison; assessed civil penalties totaling \$2,000.

Name: William A. Holland Jr., MD (Chattanooga)

Violation: Unprofessional, dishonorable, or unethical conduct; drug addiction; arrested for driving while under the influence of hydrocodone.

Action: Per agreed order, reprimanded; must complete remainder of contract and aftercare outlined by Physician's Assistance Program.

Name: Gerard Mazza, MD (Cleveland)

Violation: Prescribing anabolic steroids to a person known to be addicted to such; unprofessional, dishonorable, or unethical conduct.

Action: Reprimanded.

Name: John D. Sherrill III, MD (Bristol)

Violation: Refusal to release medical records.

Action: Assessed civil penalty of \$500.

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

Special Conferences/Seminars

Detailed brochures for the following courses are available. In some cases, registration numbers are limited.

- Aug. 8-9 Endoscopic Sinus Surgery and Revision Surgery Workshop
- Aug. 15-16 1st Clinical Oncology Symposium
- Sept. 25-28 Pulmonary/Critical Care Medicine—Destin, Fla.
- Oct. 18-19 Laryngeal Video Endostroboscopy Workshop
- Nov. 13-16 2nd Neonatology Symposium—Asheville, N.C.
- Dec. 6-7 22nd High Risk Obstetrics Seminar

For information contact Division of CME, Vanderbilt University School of Medicine, D-8211 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

Continuing Education Schedule

Memphis

- Aug. 17-22 Pharmacology of Thermoregulation
- Sept. 19-20 28th Conference on the Mother, Fetus, and Newborn

Knoxville

- Sept. 6 Hormone Replacement Conference
- Sept. 15-17 Internal Medicine Conference—Gatlinburg
- Oct. 11-12 Molecular Genetics—Clinical Applications for Primary Care
- Oct. 13-16 18th Obstetric Office Ultrasound Workshop
- Oct. 18-19 1st Pediatric Trauma Conference
- Oct. 28-30 16th Smoky Mountains Ob/Gyn Seminar—Gatlinburg
- Nov. 6-8 Advanced Cardiac Life Support Course
- Nov. 15-16 New Concepts in the Treatment of Cardiac Disorders
- Dec. 3-5 Perinatal Update '96—Gatlinburg
- April 23-25 20th Family Practice Update & Review—Gatlinburg

For information contact Mrs. Jean Taylor Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163. Tel. (901) 448-5547.

Tennessee

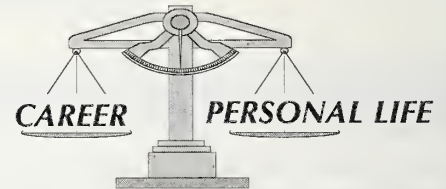


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Listings for Career Opportunities are sold as follows: \$35 for the first 50 words (\$25 for TMA members), 25 cents for each additional word. Count as one word all single words, two initials of a name, single numbers, groups of numbers, hyphenated words, and abbreviations. Advertisers may utilize a box number for confidentiality, if desired, in care of Tennessee Medicine, PO Box 120909, Nashville, TN 37212-0909. Use of this box in an ad will add eight words to the total count.

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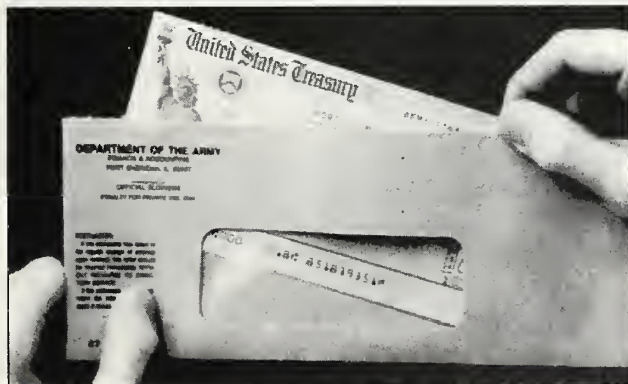
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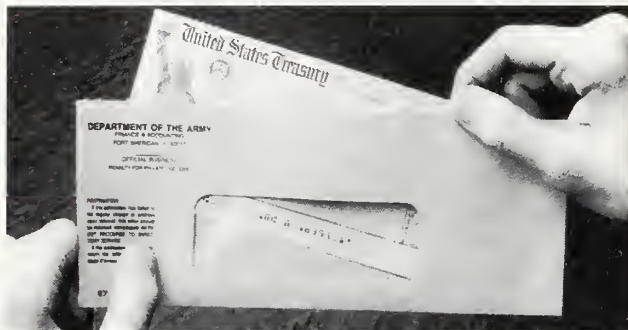
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Patriot Investment Management	304
State Volunteer Mutual Insurance Company	308
Sterling Healthcare Group	304
Team Health	293, 304
Tennessee Consultation Center	288
TN Dept. of Mental Health/Mental Retardation	301
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U.S. Army	306
U.S. Army Reserve	305

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Responsibility—The author is responsible for all statements made in his work. Although rejected manuscripts are generally returned to the author, Tennessee Medicine is not responsible for loss. Accepted manuscripts become the permanent property of Tennessee Medicine.

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References—References should be limited to 20 for major communications and 10 for case reports. All references must be cited in the text in numerically consecutive order, not alphabetically. Personal communications and unpublished data should be included only within the text. The following data should be typed on a separate sheet at the end of the paper: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, first and last pages, and year of publication. Example: Olsen JH, Boice JE, Seersholm N, et al: Cancer in parents of children with cancer. *N Engl J Med* 333:1594-1599, 1995.

Illustrated Material—*Illustrations* (preferably 5 x 7 in. glossy photos) should be identified on the back with the author's name, the figure number, and the word "top," and must be accompanied by descriptive legends typed on a separate sheet. *Tables* should be typed on separate sheets, be numbered, and have adequately descriptive titles. Each illustration and table must be cited in numerically consecutive order in the text. The Editor will determine the number of illustrations and tables to be used. Illustrations will not be returned unless specifically requested. Materials taken from other sources must be accompanied by a written statement from both the author and publisher giving Tennessee Medicine permission to reproduce them. Photos of identifiable patients should be accompanied by a signed release.

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Richard M. Pearson, MD

Energy Enough

Far removed from the halls of medicine, a controversy is raging now among theoretical physicists about how the universe began and how it will end. The Big Bang theory of the origin of stars and galaxies proposes that at one time all the energy and matter of the universe was concentrated at one point, and that with the Bang all was flung outward with enough velocity and momentum to expand forever. Enter, however, the "dark side." Forces other than the original energy, forces such as gravity, are at work pulling everything back together. Some theorists propose that the universe contains large amounts of unseen "dark matter," enough indeed to ultimately slow everything down and draw it back together in the Big Crunch.

Where are we in the universe of medicine right now? It would seem perhaps that the Big Bang for modern medicine began in the 1940s and 1950s with the advent of new technologies, modern hospitals, new pharmaceuticals, and prepaid health care. Our medical universe has expanded rapidly and massively until recently, but now appears to be reaching the limits of its initial energy. The "dark side" consists of deficit-ridden government, huge corporate ambition and profits, shareholder-driven HMOs, a sensationalized media, and misplaced personal priorities. These are pulling our health care system back into the Big Crunch, squeezing out all compassion, caring, humanity, and enthusiasm.

How is our medical universe going to proceed? Take hope! The most powerful force in medicine is the human energy for caring and helping. Commitment to selfless service is the force that drives dedicated health professionals to expand their efforts to prevent or cure illness, to comfort, and to diminish misery and suffering. It is an unstoppable force. It is an energy that all of us experience personally, and is inseparable from our lives.

On the other hand, business and government lack that personal energy or ethical vision. Often the force driving them is money and the power it entails. While they and the media currently rule our universe, take heart, because when the business and government coalition have wrung all the dollars out of the "caring" industry they will quickly lose interest. They will be anxious to unload the sick and suffering and unprofitable assets of their ventures back onto those of us who care about lives rather than bottom lines.

Your professionalism, compassion, and endurance will continue to expand the opportunities for helping the sick. This is the light of the universe. It will not go out.

R. Pearson MD

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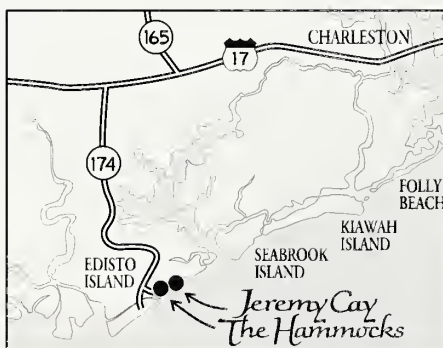


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John B. Thomison, MD

Federation Mediation Meditation— Or Hesitation? Trepidation?

People seem to learn slowly, and that mostly from experience. I would add to that, from bad experience, which has led to the aphorism that experience is a dear teacher, in the context not of beloved, but expensive. By the time wisdom has been gained from accumulated trauma, the victim is considered a pessimist because he is over the hill, and nobody listens—or even asks. “They” never put anybody over the age of 30 on long range planning committees, because, they say, it will be the whatever of the young, and the young are the ones that will have to live with it. So, OK, let them.

I have learned a lot about consortia in my 75 years. Back about 40 years ago I was on a planning committee of one. It wasn’t called that, because nobody had ever heard of a consortium back then. It was called a curriculum committee, and the consortium comprised the various departments of Vanderbilt Medical School. That, incidentally, was when a medical institution consisted of a medical school with a hospital. There were only a few medical centers, which was a medical school with several hospitals, and was so-called mainly to furnish bragging rights. They still would be except that these days no self-respecting institution can afford not to be called one. But I digress.

The committee was a large one, and we met once or twice a week for nearly a year, or maybe longer. I forget. In other words, it consumed hundreds of man-hours. The charge was to develop a mechanism to incorporate the vast increase in knowledge, with its consequent burgeoning subject matter, and hence curriculum topics, into the finite number of hours allotted the entire curriculum. A report was developed in which we told them how. It required the development of numerous elective courses. The report was widely praised, along with the committee, and then it was basically shelved, except that a number of electives were offered. The problem in effecting the requisite changes was that although everyone recognized that to accomplish what we had recommended would require cutting time from existing courses, and everyone was willing for that to be done, the director of each of those existing courses allowed as how *his* course couldn’t spare any hours. In fact, they all needed more hours, and not fewer. So much for that consortium.

A few years ago the AMA developed numerous task forces assembled from every major group in the country, such as the business roundtable, the AMA, the AHA, and God knows what all, to develop a Health Policy Agenda for the American People. And they did. Millions of dollars were spent. Nothing ever came of it. The House of Delegates of the AMA, of which I was a member, reluctantly handed the planners most of what they wanted. What nearly everybody else wanted was a pound of our flesh, and that was not negotiable, which I could have told them, and did. But I and a lot of other realists—I started to say pessimists, but I decided we were only being realistic—simply wasted our breath. The insurance industry, business generally, and the hospitals are the implacable enemies of medicine, dwarfing the federal government, and are willing to have high-quality medical care only if it doesn’t cost them money. They are not farsighted enough to perceive that poor medical care is in the long run much the more expensive alternative. So that also came to nought.

Now the planners are at it again, this time diddling with the Federation, defined up until now as the AMA and the state medical associations. Not that it didn’t need diddling with, and not that the way in which it is being done is wrong. In fact, I think the method worked out by the planners to be quite innovative. To be an effective federation it must include all, or at least most,

doctors. But I think the basic premise is defective, which is that doctors can be counted on to work together. What I see happening around me is practices being sold or entering into management contracts so that the doctors can practice medicine without the hassle of economic problems and with economic stability. The young doctors I have spoken with want an entity that can take on the insurance industry, the HMOs, the hospitals, and the government and give them those things. Those other entities are driving wedges between the specialists and the primary care physicians, and between the doctors and their patients. The practicing doctor wants to be insulated from all that.

One of the major criticisms I have heard of the AMA was, and is, about the activities of the Council on Ethical and Judicial Affairs (CEJA). Delegates who have supported CEJA have been pilloried by their constituents, who think CEJA has been treading on ground that is not in their domain. As a delegate I opposed tampering with CEJA and dictating controls, but I am not certain that the AMA can assemble medicine under the same umbrella with a freewheeling council. A Supreme Court for Medicine is a grand idea, but it has one major difference from that of the United States. Flout the U.S. Supreme Court and it lands you in jail. Do it to CEJA, and the reaction is, OK, so I'll drop out of the AMA. It has no teeth, and any attempt at establishing any gets lawsuits by the Justice Department for violation of antitrust statutes.

The younger doctors especially are not interested in a federation that tells them how to practice medicine. They get enough of that from other sources. What they are looking for is an entity that tells those other entities to get off their backs, and makes it stick. They are looking for an entity that can make threats, and has the muscle to carry through on them. They believe the AMA has sold them out on numerous occasions and gained only hollow victories at best. They, and this is not only the younger doctors, cannot see that the AMA has gained them anything, but instead has taken positions that have steadily eroded their own position. They see the AMA councils as being top-heavy with medical school faculty who they think are out of touch with reality. It is difficult to convince them that all of this is generally erroneous when all they see is erosion of their practice and income, and nothing to combat it coming from the Federation at any level. They see, therefore, money spent on the Federation as wasted.

A strong Federation of Medicine is greatly to be desired, and is I think a necessity. The path being taken, and outlined in Tim Sewell's article elsewhere in this issue of the *Journal*, entitled "Overhauling the Federation of Medicine," seems a start that deserves, if not missionary zeal, at least the support of each of us. Since I can look ahead, however, and see that it might, through maneuverings of our previously mentioned powerful opponents, be ruled in violation of antitrust statutes, and in restraint of trade, and considering past experiences, my jury is still out. I shall have to see it in action.

Celebration of a Life: Tommy Ballard, R.I.P.

Blessed are they that wash their robes clean [in the Blood of the Lamb],
that they may have right to the Tree of Life, and may enter in through
the gates into the city.

The Holy Bible, Revelation 22:14

Too often the accolades due an individual are withheld until it is time for such pieces as this or the usual memorial services. Fortunately, that was not the case with the late Thomas Kelly Ballard Jr., MD, who departed this world for his permanent home in the New Jerusalem on July 9, 1996. It is unnecessary, and perhaps even inappropriate, to recount his numerous honors and

accomplishments here, since this is neither an obituary nor a *curriculum vitae*. Those have been mentioned in recent issues of this *Journal*, mostly in the February 1996 issue, pages 58-59, in connection with his retirement from the TMA's delegation to the AMA House of Delegates. In that same context I also expressed my own feelings for and personal debt of gratitude due him.¹ Appropriately enough, Dr. Ballard's memorial service was entitled "A Service of Celebration for the Life of Dr. Thomas K. Ballard Jr." This is rather a joining in the celebration, and a farewell to a beloved friend and colleague.

Though Dr. Ballard served the various levels of organized medicine in many capacities, his chief interest was medical education, which he fostered in many ways in both the Federation and the Tennessee Academy of Family Physicians (TAFP). In that connection, the Tennessee Alliance for Continuing Medical Education (TACME) has established the "Thomas K. Ballard, MD Lectureship Fund" in recognition of his many years of support of CME in Tennessee. Details can be found in the June 1996 issue of *Tennessee Medicine*, page 190. Many young people both within and outside the confines of medicine likewise shared directly in his generosity.

The *Journal* joins his family, his many friends, and the recipients of his many kindnesses in celebrating the life of Thomas Kelly Ballard Jr., MD, at the same time extending to them our heartfelt sympathy in the sorrow of bereavement. *Ave atque vale*, Tommy.

Requiescat in pace.

1. Thomison JB: Ramblings of an ex-AMA delegate. *J Tenn Med Assoc* 89:60-62, 1996.

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AIR FORCE RESERVE

A GREAT WAY TO SERVE

Overhauling the Federation of Medicine

Tim Sewell

Later this fall, physicians in Tennessee and across the nation will receive their first specialty selection ballots used to determine the number of delegates that will be representing specialty societies at the annual and interim meetings of the American Medical Association.

According to officials, it will be the first concrete change that is likely to be noticed by physicians as a result of ongoing efforts by the AMA to more closely unite the nation's 261,000-plus physicians.

"The changing composition of the House of Delegates will be the most significant short-term effect of this effort," says AMA Board member Timothy T. Flaherty, MD. "In the long run, we hope to increase participation in organized medicine at all levels. We also want to reflect representation by the mode of practice—not just by the specialty of the practice, but also by the type of group practice."

According to resolutions passed at the AMA annual meeting in June, the number of delegate positions allocated to the specialty societies in the future will be determined by an annual ballot. Once a year, the AMA will send a specialty representation ballot to each AMA physician member and all four-year medical student members asking each member to

identify one specialty society to represent him or her in the AMA House of Delegates for the coming year. For the first three years, each specialty society will be allowed one delegate and one alternate delegate for every 2,000 AMA members who select that particular specialty society. Beginning in the fourth year, each specialty society will be allowed one delegate

and one alternate delegate for each 1,000 AMA members who select that particular society on the annual ballot. Each specialty society that meets AMA eligibility criteria will be allowed at least one delegate and one alternate delegate position regardless of the number of AMA members who select that society on the ballot.

Depending on the number of ballots returned, the 1997 House of Delegates could have up to 160 specialty society delegates. The number of specialty society delegates could increase to 290 in the year 2000. Compare that to the 82 specialty society delegates (out of a total of 414 delegates overall) at the 1995 interim meeting.

The move to increase representation of the societies in the AMA House of Delegates is a cornerstone proposal from the Study of the Federation, a two-year project designed to determine how the AMA, the state medical societies, and the specialty societies can do a better job of working together to promote the interests of physicians and their patients. Delegates to the 1995 interim meeting in December approved 19 of 34 recommendations based on the Study of the Federation report. Delegates to the 1996 annual meeting in June approved additional recommendations.

"Over the years, the nation's medical community has become more fragmented," Flaherty says. "The proposals that have come out of the Federation study will greatly change the way the AMA operates. They should help us all to work together more closely, to avoid duplication of effort, and to focus more attention on those issues that we all have in common."

The question of how to unite the nation's diverse medical community—made up of members representing a variety of specialties, practice arrangements, geographic regions, ethnic groups, and interest groups—and how to better serve those physicians in a changing health care environment has been discussed by AMA officials for the past decade. The question moved to the forefront of AMA concerns in 1993 when the Association's House of Delegates adopted a recommendation made by the Council on Long Range Planning and Development to create a broadly based consortium of Federa-

"We want to reflect representation by the mode of practice—not just by the specialty of the practice, but also by the type of group practice."

Timothy T. Flaherty, MD
AMA Board Member



Flaherty

Tim Sewell is a reporter for the Memphis Business Journal and writes frequently for the Memphis Health Care News.



Alexander

tion organizations to identify how all of medicine could function more efficiently and effectively.

That 1993 recommendation resulted in the creation of a consortium that included representatives from 200 organizations as well as a project team made up of 30 individuals. Participants were chosen from county medical societies, state societies and specialty societies,

as well as the AMA. They were selected to reflect a broad cross-section based on geography, gender, practice arrangement, age, and other key characteristics. Beginning in May 1994, the consortium met four times and the project team met eight times as members worked on the Study of the Federation project.

Don Alexander, chief executive officer of the Tennessee Medical Association, and Allen Edmonson, MD, an orthopedic surgeon from Memphis, represented Tennessee physicians as members of the consortium. The two men also headed a statewide TMA task force created to consider the proposals that came out of the Study of the Federation.

"What we call the Federation of Medicine really exists only in philosophy," Alexander says. "Medicine has gotten to the point where we are our own worst enemy because we compete with one another. This study has caused us to refocus, and to remember that we are all in the same organization and that we all have the same goals and objectives—quality medicine from a quality profession."

At the 1996 annual meeting, delegates approved a number of resolutions related to the Federation study. According to AMA officials, five principles govern each of the proposals related to the Federation of Medicine. They are as follows:

- Change is essential. The environment of medicine is changing and a status quo Federation will not be well positioned for success in the future.
- A core objective must be increased membership throughout the Federation. To do this successfully, the activities of the whole Federation must be relevant to the needs of physicians and there must be active outreach to all physicians, especially nonmembers.
- Building a common purpose, a common voice, and a common action plan will be increasingly critical to the success of all components of the Federation.
- Operational efficiency and productivity of all Federation components must be enhanced in order to reduce cost and increase the value of membership.
- Collaborative action will be critical to achieving suc-

cessful advocacy on behalf of patients and physicians.

According to Edmonson, the report is merely the first step in what promises to be a lengthy process.

"It certainly is an advance and I would hope that this effort will continue so we can be representative of a larger percentage of American physicians," Edmonson says. "Personally, I would like to have seen the AMA go further in opening itself up to specialty society members, and not just specialty society members, but other physicians who are not now represented. Some ethnic groups and members of practice groups and others feel that their interests aren't represented by the AMA. This present action will have some effect, but it's not going to solve all the problems."

Alexander says "I think the report at least addresses all the major issues. I don't know that the resulting document will solve those issues, but it is something to be said that the Federation did take a look at itself. Now, it's up to each of us to try to work on ways to solve the problems."

Officials agree that the Federation proposals over the long term should result in greater efficiency for the various medical organizations and more value for the dollar for the nation's physicians.

"The AMA membership has been drifting downward for at least five or six years. Consequently, from a political standpoint the AMA has been representing a smaller percentage of physicians each year," Edmonson says. "At the same time, the specialty societies have been growing because they coordinate the accreditation and continuing education services. When the membership dues money is tight, the AMA membership is the first to be dropped."

In Tennessee, the average physician who belongs to one of the larger metropolitan medical societies in addition to the TMA and the AMA pays almost \$1,000 per year in dues. Membership in one to three specialty societies can add up to another \$1,000 in annual membership dues.

"There are only so many dues dollars to go around," Alexander says. "If organizations don't give added value to their members, then the doctors won't join. We're all going to have to provide better service."

"Basically, we're all going to have to work together to avoid duplication," Alexander adds. "Some of us are in a better position or we're better equipped to do certain things. For any of us to survive, we'll have to reexamine those things and admit that there's a place for each of us in this. Each of



Edmonson

us is going to have to do what we do best for the good of everybody. That includes the state association. There are some things we can do better than the county societies and there are some things they can do better than we can. Let's do those things that we each do best."

Flaherty, a board-certified radiologist from Wisconsin, notes that most physicians are represented by a number of different societies, either specialty groups or geographic organizations.

"I spoke to one physician who belongs to nine different specialty societies. He is paying a huge amount of money—\$4,000 to \$4,500—in annual dues," Flaherty says. "We have the potential here to eliminate some of the duplication, and therefore some of the cost, at all levels."

As officials are quick to point out, now that the proposals have passed, the real work begins. The AMA's Council on Ethical and Judicial Affairs and the Council on Long Range Planning and Development are expected to begin work soon on a "statement of collaborative intent" that respects the autonomy of constituent organizations, but also characterizes the nature of the working relationships that must exist among all Federation members if it is to achieve its objectives. That statement has several aims, including the following:

- To promote trust and cooperation throughout the Federation of Medicine;
- To help the Federation speak with a unified voice;
- To work cooperatively with other Federation organizations to advance the image of physicians, the medical profession, and the Federation as a whole;
- To support, wherever possible, the policies established by the AMA House of Delegates;
- To openly share information that can help other Federation organizations succeed;
- To work with other Federation organizations to minimize duplication of services;
- To increase efficiency in organized medicine;
- To provide the best possible value to members through reduced dues and enhanced service; and
- To work cooperatively with other Federation organizations to achieve better communication among physicians, between physicians and their medical associations, and among the organizations that comprise the Federation of Medicine.

The Council on Long Range Planning and Development also is expected to study the current criteria that specialty societies must meet to be granted and retain representation in the AMA House of Delegates as well as the processes

"The proposals . . . should help us all to work together more closely, to avoid duplication of effort, and to focus more attention on those issues that we all have in common."

Timothy T. Flaherty, MD

through which specialty societies apply for representation in the AMA/Federation House.

AMA officials will create a Federation Coordination Team with a life span of three years to handle the various responsibilities associated with the formation of the Federation. After three years, the AMA/Federation Board

of Trustees will assume the responsibilities of the Federation Coordination Team.

"Now, we have to roll up our sleeves and get to work. That's the only way we're going to solve the issues of duplication of services and programs," Alexander says.

"It remains to be seen whether or not the organizations will be willing to give up some of their powers. If the TMA in our structure can identify things other organizations are doing better than we are, then certainly we would be willing to give up some of those things to devote more time and energy to the things we can do better. Only time will tell whether all organizations will be willing to do that. But, I guarantee you that it would never occur had we not had this discussion."

The initial action report of the Study of the Federation was sent to all participating organizations in October 1995. At the AMA's 1995 interim meeting, representatives of the Federation discussed the report and approved the fundamental promises and directions recommended as well as some of the specific recommendations related to how the new Federation should operate. Other specific aspects of the report were sent back for further work. Key among those were the formulas for specialty representation and representation by mode of practice and demographic characteristics. After further development of those ideas and the proposed implementation strategies, the final report was released in February, just four months prior to the 1996 annual meeting.

The AMA has existed in its present form since 1901 when the McCormack Committee proposed that the AMA be organized as a federation built around state medical societies. Officials say that such an organization made sense at the time for several reasons. Physicians, for instance, were more homogeneous, born and trained almost exclusively in the United States. There were, for all practical purposes, only two specialties—general practice and surgery, and there was essentially only one kind of practice—solo practice. In addition, almost all health-related regulations were managed by state or local governments. As officials point out, the practice of medicine has definitely changed with the times, and organized medicine must change with it. □

Loss Prevention Case of the Month

Postpartum Back Pain, So What!

J. Kelley Avery, MD



Dr. Avery is chairman of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

A 30-year-old gravida 1 para 0 delivered a healthy male infant under epidural anesthesia after a normal labor. She was up and ambulating as expected on the first postpartum day. She voided and was able to be discharged home the following day. On the third day home she called the physician's office twice complaining of constipation and backache. The next day she made a call and was sent Darvocet N 100 for pain. (This phone call was not recorded by the office staff as the others had been.) She complained that the back pain had been getting worse every day and that she was intermittently feverish. On postpartum day 9 she called the physician's office and again complained of increasingly severe back pain, but this time the pain seemed to be involving her legs, worse on the left. She was advised to go to the emergency department (ED) of the hospital for examination and further treatment.

The history given in the ED was a repeat of what she had given the physician on call for the Ob-Gyn group. She said again that she had delivered nine days earlier and had had an epidural anesthetic that "has been giving me problems ever since." The back pain now involved both legs and was getting worse. There was no swelling, tenderness, or redness at the injection site. Routine laboratory tests were done, and the WBC count was 18,000/cu mm with a shift to the left.

The urine showed some blood, WBCs 10 to 15/cu mm, 1+ albumin, and 3+ bacteria. On culture group D *Streptococcus* was identified which was reported as "usually susceptible to nitrofurantoin." An hour or more later in the patient's ED stay another physician, the "on-call" doctor for the Ob-Gyn group, reexamined the patient and reported some tenderness over the epidural site and questionable swelling in the area of L2-3. A neurologic examination revealed no neck stiffness, but on straight-leg raising of both legs the low back pain became severe at about 35 to 40 degrees. The evaluation was somewhat confused by her severe constipation. Digital removal of the impaction was accomplished on her admission to the outpatient department.

A neurologist consulted by phone gave a telephone order for a CT scan of the lumbar spine area, which showed a "density which appears to displace the cauda equina posteriorly and is separate from the annulus fibrosus." It suggested the presence of a "localized hematoma or area of local infection." The neurologist examined the patient on Friday, and believed transfer to a tertiary facility was not needed at the time, but did order an MRI for Monday. She continued to be febrile. Nitrofurantoin was ordered, and if the temperature went to 102°F the neurologist was to be called.

Over the next day she could not void, and an indwelling catheter became a necessity. She continued to complain of back and leg pain. She stated that her right leg now felt "dead." She could move the leg with effort. She continued to complain of being unable to have a bowel movement.

On Sunday, with the difficulty getting worse, she was transferred to the center where more definitive measures could be taken. By noon a laminectomy had been done, with a bilateral paraspinal abscess found and evacuated. Aggressive antibiotic treatment led to improvement, but there was a residual neurologic deficit involving predominantly the left leg.

A lawsuit was filed charging negligent delay in diagnosis and treatment of the post-epidural infection that led to the permanent neurologic deficit in this young mother.

Loss Prevention Comments

On admission to the ED nine days after delivery, she stated, "I had an epidural and have been having trouble with it ever since." She had called the obstetrician's office three times,

one of them not documented, complaining of constipation, not an unusual postpartum complaint, and pain that was centered in the low back, again not an unusual complaint a few days after delivery. At the time of the ED examination, she complained that the pain was involving both legs, one worse than the other.

The obstetrician found some "swelling and tenderness" over the epidural injection site, and discovered that on attempting to do straight-leg raising the back pain became severe. The CT scan ordered while she was in the outpatient department of the facility showed evidence of "hematoma or infection" in the area of the epidural.

The patient was febrile and the urine showed some infection, which, at the worst, was unimpressive even with the culture and sensitivity showing a group D *Streptococcus* sensitive to nitrofurantoin. The chemotherapy was begun, and

one has to wonder if the epidural infection could have been resolved with more aggressive antibiotic therapy at that time.

It was Friday, and in retrospect the decision to delay transfer to the tertiary care facility in the face of these findings is confusing. It was a Sunday when symptoms, including fever, forced the transfer to the center with emergency definitive care.

It is always of fundamental importance to *listen to the patient!* "I had an epidural and it has been giving me trouble ever since," she said in the ED. One cannot escape the hint that, because it was a weekend, this management of the patient led to the delay in the correct diagnosis and treatment.

A very large settlement was required to close this case. Both the obstetrician, his group, and the neurologist and his group were found negligent, and contributed to the settlement. □

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'96 Elections

Every Vote Counts

IMPACT

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America has long been hailed as the "Great Democratic Country." We fought for our independence from Great Britain in the 18th century, survived the Civil War in the 19th century, and fought overseas in the 20th century to ensure that other countries could experience democracy and free elections firsthand.

But as citizens of the "Great Democratic Country," how many actually take part in the election process? Every year the number of eligible voters continues to grow, while voter turnout declines. Congress and the Supreme Court have done away with barriers to voting. Qualifiers like literacy tests, property ownership, and race no longer prevent citizens from casting ballots.

Between 1932 and 1976, the voting-age population and the number of voters in presidential elections almost doubled. Throughout the post-World War II years until 1968, presidential election turnout hovered at 60%, with one exception. In 1948, a little more than half the registered voters cast ballots. In 1992, turnout reached a post-WWII high of 55.2%.

Groups across the country have undertaken active voter registration drives in recent years. Everyone from the unions, trade associations, and even MTV developed programs to register voters, and increase the turnout on election day.

Does one or two votes more really count in an election? Consider:

- In the 1974 race for the U.S. Senate in New Hampshire, Republican Louis Wyman led Democrat John Durkin by two votes—110,926 to 110,924. Because the election was so close, it was left up to the U.S. Senate to declare a winner. That body could not come to a consensus, so instead a rematch was held. Durkin emerged as the victor, taking 53.6% of the vote. Turnout that year was around 36%. Imagine what a few more votes would have done.

- In 1954, Sen. Strom Thurmond began his career in the U.S. Senate by winning election as a write-in candidate. Then a Democrat, he received 143,442 write-in votes to defeat his party's endorsed candidate. He's been in the Senate ever since, but switched parties in 1964.

- In 1994, a U.S. House incumbent from New York, who was opposed by organized medicine because of his legislative record, won election by a mere 55 votes. Imagine if one physician and Alliance member from each precinct in the district had voted for his opponent.

- In another 1994 race for the U.S. House, an incumbent opposed by organized medicine in Connecticut won by 21 votes. Again, if one physician and one Alliance member from each precinct had cast their ballots, the outcome could have been reversed.

The '96 Vote

In 1996, Americans will decide who leads us into the second millennium as president, not too mention who will control the U.S. House and Senate. The elections provide a visible means of voicing opinions on the leadership of the country.

Voter registration guidelines vary from state to state. Some states allow registration up to the day of the election, while others have a cut-off date 30 days prior to the election. With the passage of "Motor-Voter" legislation, registration is as easy as getting your driver's license. Check with your local elections registrar to determine guidelines in your area.

Election Tip

If you know you will be out of town on November 5, or if your practice does not afford you the time to go to the polls, request an absentee ballot or vote early. Absentee balloting begins on September 6 and early voting starts October 16.

One way for physicians to participate in the political process is to contribute to IMPACT-TMA's political action committee. Join IMPACT today and become involved for your profession. □

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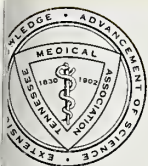
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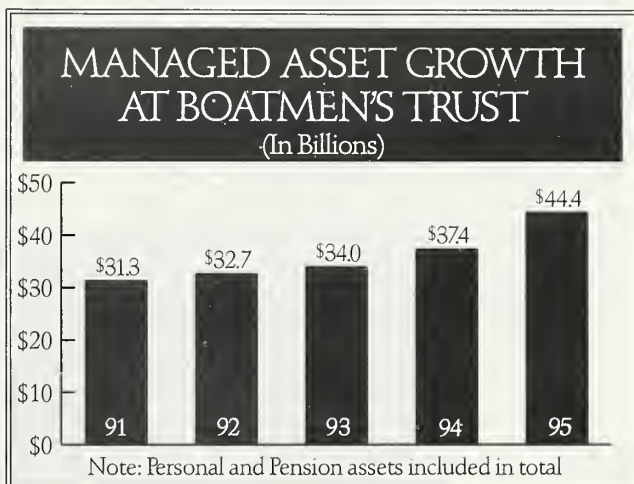
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Original Contribution

Catheter-Associated Central Venous Thrombosis

Ryland P. Byrd Jr., MD; Robert W. Lukeman, MD; Mathew Mathai, MD; and M. K. Mathew, MD

Introduction

Deep venous thrombosis of the lower extremities is widely recognized as a leading cause of pulmonary embolism. By contrast, upper extremity venous thrombosis is less common and early observations suggested that pulmonary embolism rarely occurred.^{1,2} The increased use of deep venous catheters, however, has resulted in a higher incidence of both central vein thrombosis and pulmonary embolization. Thrombosis of the central venous circulation may occur in as many as 50% of all patients with subclavian catheters.³ Pulmonary embolization effects 12% to 20% of patients with catheter-associated thrombosis.^{4,6} In view of the potential morbidity and mortality associated with catheter-induced thrombosis we report a case and review the literature.

Case Report

This 35-year-old female manic depressive complained of left arm pain and swelling, as well as mild shortness of breath, for one week. She had recently been discharged from the hospital where she had been treated for haloperidol-induced malignant hyperthermia. She had received dantrolene and hydration by left subclavian vein infusion. Her past history was significant only for manic depressive psychosis, for which she was taking no medications at the time.

Her vital signs were normal except for a respiratory rate of 24/min. Her left arm was edematous, with superficial venous engorgement. There was no palpable venous cord, evidence of phlebitis, or loss of sensation in her left upper extremity. The remainder of her physical examination was unremarkable.

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ABSTRACT

Because of the frequent use of central venous catheters, deep venous thrombosis of the upper extremity is more common than previously reported. A significant number of patients suffer pulmonary embolization from catheter-associated thrombosis. This observation should be considered as a major factor in the risk benefit analysis of the utility of deep venous catheters.

Her laboratory data included a normal WBC count, hemoglobin, platelet count, serum electrolytes, and biochemical survey. Her prothrombin time and partial thromboplastin time were normal. Ultrasound studies of her left subclavian vein

documented extensive thrombus formation (Fig. 1). A ventilation/perfusion scan to determine the likelihood of pulmonary thromboembolism was classified as a high probability scan for the presence of pulmonary emboli (Fig. 2).

Discussion

Iatrogenic causes rank first as the etiology of upper extremity thrombosis.^{6,7} Placement of these indwelling catheters interrupts and damages the vascular endothelium, and the presence of the catheter in the vessel lumen causes turbulence of the venous flow, with release of procoagulants.^{7,8} Underlying hypercoagulable states associated with comorbid illnesses may further increase the risk of catheter-related thrombosis development.^{4,7,9}

Catheters placed in the subclavian vein are the most frequently implicated in thrombus formation, though catheters placed at other sites are also associated with upper extremity thrombosis.^{6,10} Catheter composition is important, and thrombophlebitis is more likely with polyvinyl chloride and polyethylene catheters than with polyurethane and siliconized catheters.^{4,11-13} Heparin bonding of catheters also reduces thrombotic complications.¹⁴ Difficulty with catheter placement is associated with an increased risk of venous thrombosis, probably due to repeated endothelial injury.¹⁵

Although the clinical signs and symptoms of upper extremity thrombosis are nonspecific and insensitive, they serve as important signals to guide the physician to more specific diagnostic tests. Patients often complain of a distal, dull ache of the involved extremity, typically associated with swelling, and occasionally of paresthesias. The pain is exacerbated by

activity and relieved by rest.¹⁶ Physical examination usually reveals a firm non-pitting circumferential edema and superficial venous engorgement. Loss of sensation in a non-dermatomal distribution may be present.¹⁷

Venography remains the standard test to detect upper extremity deep venous thrombosis,⁶ though this type of imaging is invasive and is not without risk. Impedance plethysmography has been used with variable results.¹⁸ Ultrasonography of the upper extremity has a sensitivity and specificity of 78% and 92%, respectively.⁹ Collateral circulation, present in 85% of patients with upper extremity thrombosis, may cause ultrasound studies to be falsely negative.^{6,18} The combination of plethysmography and ultrasonography results in an acceptable specificity and sensitivity of 90%.¹⁹

Catheter-related thrombosis predisposes the patient not only to pulmonary embolization but also to bacteremia. The incidence of positive blood cultures is higher in patients with catheter-related thrombosis than in patients with deep venous catheters without thrombosis.¹⁴ The reason for this is not well understood.

When catheter-associated thrombosis is discovered, the involved extremity should be elevated, placed at rest, and have local heat applied. Antithrombotic therapy should be initiated. Thrombolytics followed by heparin has recently been used with success.²⁰ While antithrombotic therapy may also preserve the function of a deep venous catheter, it may continue as a source of recurrent thrombosis formation and must be removed.¹⁵ Removal of the catheter, however, may cause a shower of emboli to the pulmonary vasculature.^{4,6} Further studies are necessary to determine the optimal time to remove a deep venous catheter to minimize the incidence

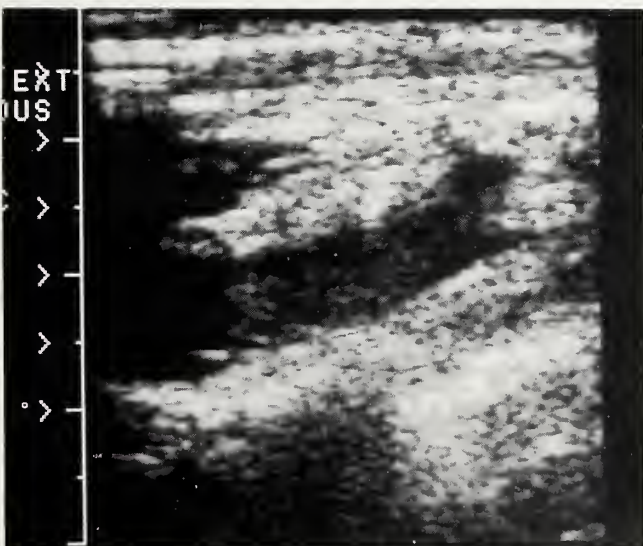


Figure 1. Ultrasound study documenting an extensive thrombus in the left subclavian vein.

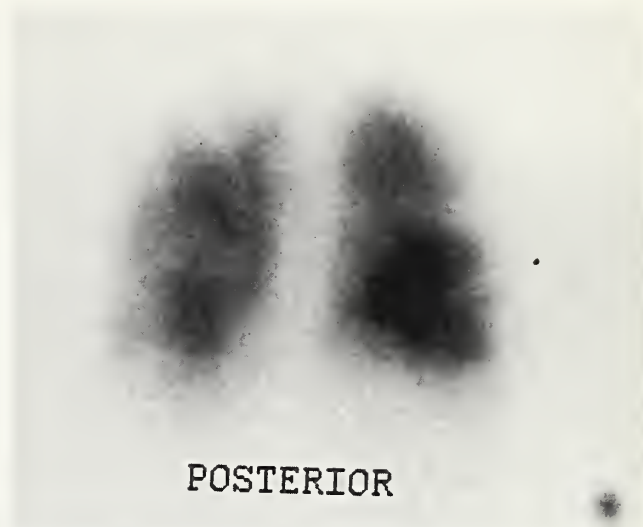


Figure 2. High probability ventilation/perfusion scan.

of pulmonary embolization.

Prophylaxis against catheter-associated subclavian vein thrombosis has been studied only in cancer patients. This subgroup of patients benefitted from a fixed low dose of warfarin, demonstrating a significantly lower incidence of thrombotic complications for at least 90 days.²¹ This observation may be extended to other patients in the future. □

References

1. Tilney NJ, Griffiths HJG, Edwards EA: Natural history of major venous thrombosis of the upper extremity. *Arch Surg* 101:792-796, 1970.
2. Swinton NW, Edgett JW, Hall RJ: Primary subclavian-axillary vein thrombosis. *Circulation* 38:737-745, 1968.
3. Groeger JS, Lucas AB, Coit D: Venous access in the cancer patient. *Principles and Practice of Oncology Updates* 5:1-13, 1991.
4. Monreal M, Raventos A, Lerma R, et al: Pulmonary embolism in patients with upper extremity DVT associated to venous central lines—a prospective study. *Thromb Haemost* 72:548-550, 1994.
5. Monreal M, Lafoz E, Ruiz J, et al: Upper-extremity deep venous thrombosis and pulmonary embolism. *Chest* 99:280-283, 1991.
6. Horattas MC, Wright DJ, Fenton AH, et al: Changing concepts of deep venous thrombosis of the upper extremity—report of a series and review of the literature. *Surgery* 104:561-567, 1988.
7. Donayre CE, White GH, McBringer SN, et al: Pathogenesis determines late morbidity of axillosubclavian vein thrombosis. *Am J Surg* 152:179-184, 1986.
8. Painter TD, Kerpf M: Deep venous thrombosis of the upper extremity: five years experience at a university hospital. *Angiology* 35:743-749, 1984.
9. Hughes MJ, D'Agostino JC: Upper extremity deep venous thrombosis: a case report and review of current diagnostic/therapeutic modalities. *Am J Emerg Med* 12:631-635, 1994.
10. Bradway W, Biondi RJ, Kaufman JL, et al: Internal jugular thrombosis and pulmonary embolism. *Chest* 80:335-336, 1981.
11. Welch GW, McKeel DW, Silvestein P, et al: The role of catheter composition in the development of thrombophlebitis. *Surg Gynecol Obstet* 138:421-424, 1974.
12. Borow M, Crowley JG: Evaluation of central venous catheter thrombogenicity. *Acta Anaesth Scand* 81:59-64, 1985.
13. Bozzetti F, Scarpa D, Terno G, et al: Subclavian venous thrombosis due to indwelling catheters: a prospective study on 52 patients. *JPEN* 7:560-562, 1983.
14. Krafft-Jacobs B, Sivit CJ, Mejia R, et al: Catheter-related thrombus in critically ill children: comparison of catheters with and without heparin bonding. *J Pediatr* 126:50-54, 1995.
15. Gould JR, Carlsson HW, Skinner WL: Groshong catheter-associated subclavian venous thrombosis. *Am J Med* 95:419-423, 1993.
16. Adams JT, DeWeese JA: "Effort" thrombosis of the axillary and subclavian veins. *J Trauma* 11:923-930, 1971.
17. Cromwell DL: Effort thrombosis of the subclavian and axillary vein: review of the literature and case report with follow up venography. *Ann Intern Med* 52:1137-1143, 1960.
18. Horne MK, Mayo DJ, Alexander HR, et al: Upper extremity impedance plethysmography in patients with venous access devices. *Thromb Haemost* 72:540-542, 1994.
19. Sottiturai VS, Towner K, McDonnell AE: Diagnosis of upper extremity deep venous thrombosis using noninvasive technique. *Surgery* 91:582-585, 1982.
20. Pires LA, Jay G: Upper-extremity deep-venous thrombosis: thrombolytic therapy with anistreplase. *Ann Emerg Med* 22:748-750, 1993.
21. Bern MM, Lokich JJ, Wallach SR, et al: Very low doses of warfarin can prevent thrombosis in central venous catheters: a randomized prospective trial. *Ann Intern Med* 112:423-428, 1990.

Department of Health Report

Office of Rural Health: Forging the Future of Rural Health Recruitment and Retention

Bill Jolley, MPA

Most rural communities know all too well that a shortage of health care professionals exists in a number of rural areas throughout the state. Policymakers in Tennessee are now being forced to formulate new strategies that offer proper incentives to physicians and mid-level practitioners to practice in underserved rural areas. While hospitals, primary care associations, medical associations, and individual communities have traditionally engaged in recruitment and retention activities, the Tennessee Department of Health (TDH) has also begun to play a major role in this area as well. Through its role in rural recruitment and retention, the TDH Office of Rural Health is beginning to make an impact on the availability and accessibility of health care providers in Tennessee.

In response to shortages of primary care providers in Tennessee's underserved areas, the General Assembly enacted the Health Access Incentive Act in 1989. The legislation was developed from the findings of the Governor's Indigent Care Cabinet Council, which was charged with studying the issue of indigent health care in Tennessee. The act authorizes a special account, the Health Access Incentive Fund, which makes financial resources available for the development and implementation of programs designed to encourage the location of practitioners in areas of the state having an inadequate number of primary care providers. This special account requires no state appropriation, since funds are allocated from the state's abandoned property account. This program has been recognized as one of the most aggressive and innovative in the country, affecting access to health care for all citizens.

Traditionally, funding for the Health Access Incentive Program has provided financial incentives ranging as high as \$75,000 for primary care providers, which can be utilized for repaying outstanding educational loans, start-up expenses, purchase of equipment, a \$5,000 locum tenens payment for

solo physicians, and technical assistance. These incentives are provided to physicians, nurse practitioners, certified nurse midwives, and physician assistants practicing primary care (family practice, general internal medicine, general pediatrics, or obstetrics) who establish a new practice in state-designated underserved areas for a minimum obligated period of 2½ years.

In conjunction with the Office of Rural Health, a newly established Assessment and Planning Section of the TDH is charged with the task of assessing the various needs of communities in the state, including primary care needs. A regional recruitment and retention committee works with both state and local entities in identifying appropriate practitioners who could satisfy an underserved community's primary care needs. Incentives are then awarded to a provider only upon the recommendation of the recruitment committee.

As of Jan. 1, 1996, 124 primary care physicians and 32 mid-level practitioners have received support through the state's incentive program. By specialty, 71 family practitioners (14 of whom provide obstetrical services), 25 internal medicine specialists, 18 obstetricians, 9 pediatricians, 1 preventive medicine physician, 10 nurse practitioners, 9 family nurse practitioners, 4 certified nurse midwives, and 9 physician assistants have received grants to locate in underserved communities. Sixty-nine counties have already benefitted from the services of these providers since July 1989. One way in which they benefit is that providers who have been placed through the Health Access Incentive Program have agreed to see patients regardless of their ability to pay and are required to participate in TennCare. While this program has brought about tremendous strides in access to care, however, it is by no means the total solution to Tennessee's health access needs. The state alone cannot be expected to continue to provide these financial incentives within all underserved areas at the current level of funding. These incentives and others that currently drive the structure of the health professions work force will not completely solve the problems of provider distribution and composition. Without some addi-

From the Tennessee Department of Health, Nashville. Mr. Jolley is director of the Office of Rural Health and Health Access at TDH.

tional interventions, problems are likely to continue.

Another activity that has also proven very beneficial in identifying excellent candidates for both rural and urban underserved communities is Tennessee's Annual Medical Recruitment Fair, which will be held on Sept. 11-13, 1996 at the Sheraton Music City Hotel in Nashville. Primary care providers from the southeastern United States are invited to participate. These providers are given the opportunity to discuss current and future practice opportunities with representatives from Tennessee's underserved communities. Information explaining the Health Access Incentive Program is also available at the fair.

The TDH is also in the final stages of approving policy to establish the "Conrad State 20" program. Under current law, foreign medical graduate physicians who come to the United States to complete residency programs are issued J-1 visas. They must return to their home country for at least two years before they are eligible to apply for U.S. citizenship or immigrant resident status. The federal regulations allow for a waiver of the requirement to leave the country if the physician agrees to work at least three years in an underserved area, among other conditions. Until very recently, the J-1 visa waiver program was controlled through the federal United States Information Agency and the Immigration and Naturalization Service, with little state-level participation. Congress passed an amendment to the law in 1994 that allows states to sponsor up to 20 J-1 visa waivers under federal rules. The Office of Rural Health is designated to administer the J-1 visa waiver program in Tennessee. Once in place, the TDH believes this program will add a new dimension to recruiting providers into Tennessee's underserved areas.

Over the past year, the TDH has received applications from physicians for visa waiver opportunities in Tennessee, and has been approached by organizations and hospitals expressing frustration about not finding physicians to meet their current needs and a corresponding desire to explore and participate in the new, state-based J-1 visa waiver program. For these

reasons, the TDH has promulgated rules and guidelines for the approval and use of foreign medical graduate physicians in our underserved areas. The TDH has included additional requirements beyond the federal mandates that will strengthen responsibilities of the providers and assure their placement in those communities that are most underserved. Facilities located within health professional shortage areas, but ineligible for the "Conrad State 20," are still free to pursue the hiring of J-1 physicians through other avenues, such as the U.S. Department of Agriculture or the Appalachian Regional Commission, both of which sponsor J-1 visa waivers.

In addition to these state-specific activities, the Office of Rural Health also administers the National Health Service Corps (NHSC) Program. The NHSC is a component of the U.S. Public Health Service's Bureau of Primary Health Care that recruits health care professionals for communities that lack adequate access to primary care services. This program assists in the development, recruitment, and retention of community-responsive, culturally competent primary care providers to serve persons in health professional shortage areas. The NHSC is also vitally interested in providing exceptional preclinical, clinical, and postgraduate experiences, as well as financial assistance programs, for health professionals. This program includes loan repayment, scholarships, externships, clerkships, and community service programs.

Now is a critical time for states to consider their role in developing the health care work force, particularly primary care providers. The primary reason for state involvement is that the marketplace alone is unlikely to produce sufficient primary care providers willing to serve rural and underserved areas. It will take both the private sector and public agencies, each doing its part, to tackle the issue of health access for all of our citizens.

Anyone interested in more information on the Health Access Incentive Program, National Health Service Corps Program, or a J-1 visa waiver application should contact the Office of Rural Health at (615) 741-0388 or (800) 659-3010. □

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Special Communication

Stroke Prevention: Recommendations

The Secondary and Tertiary Prevention of Stroke Patient Outcomes Research Team (PORT) has established important findings about the most cost-effective treatments for people at high risk for stroke. The PORT is a five-year research study supported by the Agency for Health Care Policy and Research (AHCPR).

These findings have led to the following recommendations for the treatment of patients with atrial fibrillation and transient ischemic attack/minor stroke (Figs. 1 and 2).

Patients with Atrial Fibrillation

Prescribe Warfarin Unless Risk of Stroke Is Low or Use Is Contraindicated

- Anticoagulant treatment is particularly effective for patients with atrial fibrillation and any one of the following additional risk factors: age >60, prior stroke, diabetes, hypertension, and heart disease.

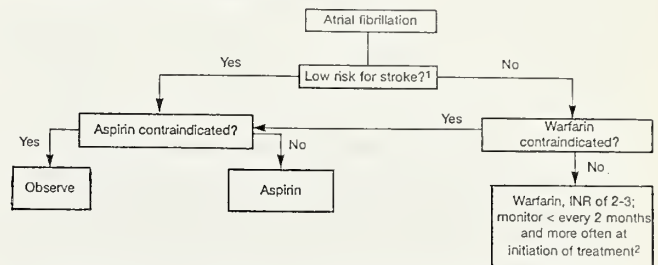
- Aspirin may be used if warfarin is contraindicated, unless aspirin also is contraindicated.

Use Good Anticoagulation Monitoring Techniques

- Avoid overanticoagulation, which is associated with a higher risk of bleeding complications.

- Monitor patients every two to three days at the beginning of warfarin therapy until International Normalized Ratio (INR) is stabilized (range: 2-3). When stabilized, monitor at least every two months.

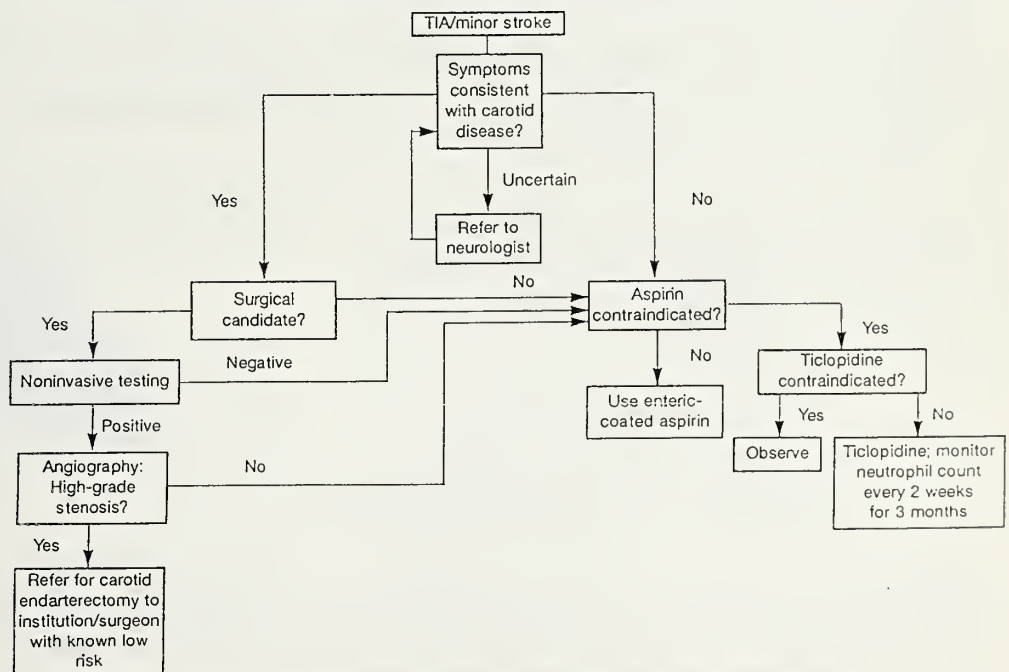
FIGURE 1—Atrial Fibrillation



¹ Low stroke risk: age <60 years with none of the following: previous transient ischemic attack/stroke, hypertension, diabetes mellitus, congestive heart failure, echocardiogram with left atrial enlargement, or global left ventricular dysfunction.

² INR: International Normalized Ratio is a measure of prothrombin time that adjusts for differences in thromboplastin reagents used by different laboratories. INRs between 2 and 3 are currently considered optimal for atrial fibrillation patients.

FIGURE 2—Transient Ischemic Attack (TIA)/Minor Stroke



¹ This algorithm is not intended to be a comprehensive management strategy for patients with TIA or minor stroke.

These recommendations are drawn from Secondary and Tertiary Prevention of Stroke Patient Outcomes Research Team: Seventh Progress Report, March 31, 1995, David B. Matchar, MD, Principal Investigator, at Duke University's Center for Health Policy Research and Education.

- Check patients within seven days after beginning or ending medication known to affect warfarin response.

- Consult drug interaction tables. Many classes of drugs such as antibiotics and anticonvulsants (e.g., phenobarbital and Tegretol) can interfere with anticoagulation.

- If possible, refer patient to an anticoagulation service for ongoing monitoring.

Patients with Transient Ischemic Attack/Minor Stroke

If Symptoms Suggest Transient Ischemic Attack or Stroke

- Determine if symptoms are consistent with carotid disease.

- If uncertain of diagnosis, refer to a neurologist.

- If symptoms are consistent with carotid disease, evaluate with noninvasive tests and/or angiography for presence and degree of stenosis.

If Carotid Disease Is Confirmed, Consider Carotid Endarterectomy (CE)

- CE is most cost-effective for treatment of patients with

high-grade stenosis (greater than 70% blockage) and transient ischemic attack or minor stroke.

- CE is not cost-effective for patients with low-grade stenosis (less than 30% blockage) or those without other signs or symptoms consistent with high risk for stroke.

If CE Is Indicated, Send Surgical Candidates to Surgeons and Hospitals with Low Rates of Complications for CE

- There is wide variation in surgical risk, depending on surgeon, operating team, and hospital.

- Hospitals should be encouraged to monitor complication rates for CE to promote informed decision making by patients and referring physicians.

Treat Nonsurgical Candidates with Aspirin or Ticlopidine Unless Contraindicated

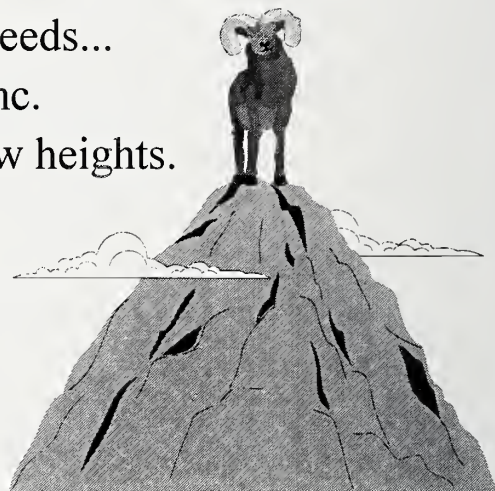
- Patients on aspirin should use an enteric-coated variety that is less likely to be associated with gastrointestinal side effects.

- Patients on ticlopidine should have a neutrophil count according to manufacturer directions. □

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Trauma Rounds

Management of the Pregnant Patient With Acute Spinal Cord Injury

Craig R. Nunn, MD; John G. Bass, BA; and Virginia A. Eddy, MD

Introduction

Traumatic acute spinal cord injury (ASCI) continues to exert a profound and long-term medical, social, and economic impact on the estimated 200,000 to 250,000 existing cases in the United States.¹ Although a majority of these injuries are incurred by men, 30% of individuals with ASCI are women.² More than 3,000 women of childbearing age sustain ASCI each year in the United States.³ Additionally, women with spinal cord injury appear to remain completely fertile and show no increased risk of birth defects or spontaneous abortion.⁴ Consequently, pregnancy complicated by spinal cord injury is neither rare nor insignificant. Optimal management of the pregnant patient with ASCI involves a number of important factors influencing both the mother and the fetus. A clear understanding of the implications of pregnancy in the trauma victim is essential to ensure an optimal outcome for both patients. Pregnancy complicated by acute quadriplegia highlights several of these issues.

We present a case of a woman in her second trimester of pregnancy who suffered ASCI from blunt trauma. Important concerns of initial and long-term management are discussed.

Case Report

A 19-year-old gravida 1, para 0, black woman at 21 weeks estimated gestational age (EGA) by menstrual dates was an unrestrained driver involved in a motor vehicle crash. At the scene, she was amnesic to the event and found to have no sensation or motor function below the shoulders. Her back and neck were immobilized, and after a 30-minute extrication, she was transported by ground EMS to the Vanderbilt University Medical Center emergency department (ED). On initial evaluation, she was found to be hemodynamically stable and alert. Blood pressure was 126/47 mm Hg, heart rate 101/min, and respirations 20/min. Oxygen saturation was 99% on 40% FiO₂ by face mask. Fetal heart tones (FHT) were auscultated in the left lower abdominal quadrant at a rate of 130/min. Abdominal examination revealed a gravid uterus to the level of

the umbilicus. The bony pelvis was stable and the bimanual examination demonstrated no blood or amniotic fluid and no effacement or dilatation of the cervix. Neurologic examination revealed complete sensory and motor deficits below C-4. The remainder of the physical examination was unremarkable.

CT of the abdomen and pelvis was unremarkable except for a normal fetus and placenta. Head CT showed no evidence of intracranial injury. Cervical spine x-rays and CT scan showed C-4 and C-5 fractures with a 40% canal compromise. The methylprednisolone protocol was started with a 30 mg/kg bolus administered in the ED, followed by a continuous infusion of 5.4 mg/kg/hr for the ensuing 23 hours. High-risk obstetric consultation was obtained, and pelvic ultrasound confirmed a viable fetus without signs of abruptio placentae. The patient remained alert and hemodynamically stable throughout the diagnostic studies, and was transferred to the surgical intensive care unit (ICU) with the diagnosis of C-5 compression quadriplegia. Adequate alignment was achieved by halo ring traction.

On post-injury day 1, her respiratory function rapidly deteriorated and she was orotracheally intubated and placed on ventilatory support. Her heart rate was 118/min, and blood pressure 90/62 mm Hg after intubation. A pulmonary artery catheter and arterial line were also placed because of the need for continuous volume resuscitation in the face of marginal urine output (0.5 cc/kg/hr), and 3.5 liters of isotonic crystalloid boluses during the first 24 hours. A continuous dopamine infusion was initiated at a rate of 3 µg/kg/min. BUN (8.0 mg/dl), creatinine (0.6 mg/dl), and lactic acid levels (1.5 mEq/L) all remained in the normal range throughout her resuscitation. Her preload indices (RVEDVI 78 cc/sq m, PAOP 8 mm Hg) were adequate, and her hemodynamic parameters were consistent with high quadriplegia (SVRI 1,100 dyne sec/cc/sq m, CI 5.2 L/min/sq m). Nutrition was provided enterally and adjusted for the injury and pregnancy. Low molecular weight heparin therapy was initiated to prevent deep venous thrombosis and pulmonary embolus.

The patient remained alert and interested in the progress of her pregnancy. Her pulmonary insufficiency worsened over the course of the next week and she developed a right lower

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lobe infiltrate. She responded well to antibiotic therapy. Because of continued secretions and inadequate spontaneous tidal volumes, the patient received a percutaneous tracheostomy on hospital day 11. She continued to do well and was transferred to the intermediate care unit on hospital day 13. Posterior cervical spine stabilization was carried out without complication on hospital day 17. Over the ensuing weeks, the patient developed another bout of pneumonia (*Acinetobacter*). She again responded to antibiotic therapy and aggressive pulmonary toilet. Her pregnancy progressed normally, and at 32 weeks EGA she received dexamethasone to accelerate fetal lung maturation. Fetal monitoring continued daily. She was successfully weaned from the ventilator eight weeks post-injury.

At 34 weeks EGA and 92 days post-injury, the patient's amniotic membranes ruptured, and she had an uncomplicated vaginal delivery of a healthy, 5 lb 3 oz baby boy (Apgar scores were 8, 9 at 1 and 5 minutes, respectively). Her postpartum course was unremarkable. She received a venacaval filter under ultrasound guidance and was transferred to a rehabilitation facility on postpartum day 5.

Discussion

The earliest accounts of paraplegic and quadriplegic women giving birth established the ability of these women to carry pregnancies to term.⁵ More recent experience has demonstrated that women with paraplegia and even quadriplegia may have normal, spontaneous, vaginal delivery, with cesarean delivery reserved for the usual obstetric complications.⁶ Although the neurologic and hemodynamic consequences of ASCI, including quadriplegia, are well documented, a number of problems are unique to the management of the pregnant patient with both the acute and chronic spinal cord injury.

The initial management of the trauma victim starts with the ABCs as defined by the American College of Surgeons' ATLS protocols. All attention should be focused toward the evaluation, resuscitation, and treatment of the mother.⁷ There are very few situations in which deviation from the ATLS protocol is indicated, a rare exception being trauma in the third trimester of pregnancy, when a Doppler ultrasound for detection of FHT should be included in the primary survey.⁸ Recently, Morris et al⁸ established the presence of FHT to be a simple, rapid, reproducible, and important marker of fetal viability. They recommend that the Doppler assessment of FHT be elevated to a component of the primary survey performed on trauma patients during the third trimester of pregnancy. In most circumstances, the support of maternal life is the best means of preserving fetal viability. Notably, once frank shock develops in the mother, fetal survival may drop to near 20%.⁹ Appropriate evaluation includes all necessary radiographic and diagnostic procedures. Shielding of the fetus is appropriate when feasible, although indicated diagnostic studies should not be eschewed in order to spare the fetus

TABLE 1
PHYSIOLOGIC CHANGES OF PREGNANCY

Parameter	Direction of Change	Trimester of Max Deviation	Amount of Change
Heart Rate	↑	3	15-20/min
Blood Pressure	↓	2	50%
Cardiac Output	↑	2,3	30%-40%
Hematocrit	↓	2	10%
WBC Count	↑	3	25%-100%

possible exposure to ionizing radiation.¹⁰ The greatest risk for inducing anomalies occurs during organogenesis at 3 to 16 weeks gestation; beyond 20 weeks, the risk of radiation-induced fetal abnormalities is low.¹¹ In the case of blunt trauma, cervical spine immobilization, including the need for log rolling and transfer on a long back board, should be initiated at the accident scene by EMS and continued until definitive operative repair or treatment is undertaken.

The North American Spinal Cord Injury Study (NASCIS), a double-blinded, placebo-controlled trial, demonstrated the efficacy and safety of methylprednisolone in patients with ASCI from blunt trauma when treated within eight hours of the injury. Motor and sensory improvement was seen in complete and incomplete cord injury (as compared to placebo).¹² No clear data have been presented in the selected subset of pregnant cord injury victims, and the risk-benefit ratio of treatment must be considered. Since steroids are frequently given to high-risk fetuses to accelerate fetal pulmonary development, the high-risk obstetrician is likely to approve the 24-hour methylprednisolone protocol for the pregnant, blunt ASCI patient.

One of the most difficult aspects of managing the pregnant trauma patient revolves around the interpretation of cardiovascular and hematologic parameters. Significant physiologic perturbations occur as normal pregnancy progresses. Failure to recognize and understand the effects of these changes can lead to delays in the treatment of the pregnant trauma victim. The pregnant ASCI patient is no exception.

Plasma volume expansion begins at about 10 weeks into the pregnancy, peaks at 32 to 34 weeks, and reaches 145% of pregravid levels by term. Red cell mass also increases, but to a lesser extent than the plasma volume, and causes a relative "physiologic anemia" of pregnancy. At term, normal levels of hemoglobin and hematocrit are 12 gm/dl and 36%, respectively. The relative hypervolemia of pregnancy has a recognized protective effect in that a 30% to 35% blood volume loss can occur prior to a change in the heart rate and blood pressure. However, this extra physiologic reserve means that once a change in the vital signs takes place, a more substantial blood loss has occurred, and a larger resuscitation should be anticipated.¹⁰

The normal values for heart rate and blood pressure also change throughout pregnancy. The pulse rate increases an average of 15/min by the third trimester.¹³ The diminished systemic vascular resistance associated with pregnancy may

also cause systemic blood pressure to be somewhat lower than normal, especially during the second trimester. Cardiac output increases 30% to 40% as early as 10 to 12 weeks gestation, at which time a 6-7 L/min cardiac output is normal (Table 1). Hypercoagulability is also seen in pregnancy owing to increased levels of circulating fibrinogen and factor VIII.¹⁰

Particular to the case of the ASCI pregnant victim is the difficulty of establishing the etiology of hypotension. While high spinal cord lesions can result in hemodynamic derangements, including neurogenic shock, the possibility of hemorrhage must be entertained and expeditiously ruled out in every trauma victim. Invasive monitoring with a pulmonary artery catheter and arterial blood pressure monitoring in the surgical ICU is appropriate to assist in the evaluation and treatment of the often confounding hemodynamic parameters. The treatment of neurogenic hypotension involves volume resuscitation and raises the question of the safety of inotropic pressor agents such as dopamine. Specific concerns about the use of dopamine during pregnancy have been addressed. Although animal studies reveal diminution of uterine blood flow (rates 5-20 $\mu\text{g/kg/min}$) by as much as 29%,¹⁴ other reports have failed to identify adverse effects from the long-term use of dopamine in humans.¹⁵ Again, the risk-benefit ratio must be assessed in the decision to use inotropic agents.

Additional supportive measures include aggressive pulmonary toilet, pressure sore precautions, and therapies to minimize the occurrence and propagation of deep venous thromboses in this high-risk population. Of extra concern is the need for early intubation for ventilatory support. These patients are likely to have difficult airways due to the oropharyngeal edema associated with pregnancy. This edema, compounded by the cervical spine instability, lends credence to the idea that early intubation will minimize the risk and anxiety attendant in establishing such a difficult airway.

Although the injury to the patient may not directly affect the fetus, maternal hemodynamic instability may result in fetal distress or demise. *Consideration of fetal monitoring must begin with the assessment of fetal viability.* There is no point in monitoring a fetus that cannot survive the extrauterine environment. An EGA of 26 to 28 weeks is generally considered the limit of fetal viability, although this remains a point of intense debate. For gestation prior to fetal viability, periodic assessment of FHT is sufficient to confirm a living fetus.^{8,10} More frequent assessment and confirmation of FHT serves mainly to alleviate apprehension of the staff. Beyond the 20th week, obstetric consultation is recommended to assess the patient for uterine contractions and FHT.¹⁰

There are several problems specific to the spinal cord injured patient in labor. These include the inability to feel uterine contractions, failure to recognize rupture of the amniotic membranes, and most important, autonomic hyperreflexia (AH).

Autonomic hyperreflexia or autonomic dysreflexia are

among the more frequent and potentially morbid complications of spinal cord injured women in labor. First described in 1917 by Head and Reddoch,¹⁶ AH occurs in as many as two-thirds of women with lesions above the T-6 level and frequently occurs secondary to distention of the bladder, rectum, or cervix. AH results from a massive, uncontrolled sympathetic and parasympathetic discharge. The underlying problem is a loss of hypothalamic inhibition of sympathetic spinal reflexes. AH may occur with partial or complete spinal cord injury, and leads to severe vasoconstriction.¹⁷ Signs and symptoms of AH include severe hypertension, headache, respiratory distress, bradycardia, tachycardia, paresthesias, diaphoresis, flushing, and piloerection. Typically, during labor the symptoms of AH peak with the uterine contractions and resolve during periods of uterine relaxation. Uteroplacental vasoconstriction can result in fetal hypoxia and distress. There is a broad range in the severity of AH, and the symptoms abate completely postpartum. In susceptible patients, epidural anesthesia is effective in blocking AH induced by labor.² Close hemodynamic monitoring of the patient and continuous fetal monitoring are essential, and cesarean delivery may be required to alleviate the most severe manifestations of AH.¹⁷

In conclusion, the management of a pregnant woman with spinal cord injury is complicated and requires a multidisciplinary, team-oriented approach. Recognition and early intervention of problems unique to this select patient population should result in the optimal outcome of the mother and the fetus. In this case, the trauma team, surgical intensivists, neurosurgeons, high risk obstetricians, pediatricians, rehabilitation personnel, and social workers provided the necessary support and planning to bring this tragedy to its optimal conclusion. \square

References

1. Price C, Makintuhee S, Herndon W, et al: Epidemiology of traumatic spinal cord injury and acute hospitalization and rehabilitation charges for spinal cord injuries in Oklahoma, 1988-1990. *Am J Epidemiol* 139:37-47, 1994.
2. ACOG Committee Opinion: Committee on Obstetrics: Maternal and Fetal Medicine Number 83-May 1990: Management of Labor and Delivery for Patients with Spinal Cord Injury. *Int J Gynecol Obstet* 36:253-254, 1991.
3. Cross LL, Meythaler JM, Tuel SM, et al: Pregnancy, labor and delivery post spinal cord injury. *Paraplegia* 30:890-902, 1992.
4. Fitzpatrick WF: Sexual function of the paraplegic patient. *Arch Phys Med Rehab* 55:221, 1974.
5. Rossier AB, Ruffieux, Ziegler WH: Pregnancy and labor in high traumatic spinal cord lesions. *Paraplegia* 7:210-216, 1969.
6. Greenspoon JS, Paul RH: Paraplegia and quadriplegia: special considerations during pregnancy and labor and delivery. *Am J Obstet Gynecol* 155:738-741, 1986.
7. *Advanced Trauma Life Support Course Book*. Chicago, American College of Surgeons, 1990.
8. Morris JA Jr, Rosenhow TJ, Jurkovich GJ, et al: Infant survival following c-section for trauma. *Ann Surg*, to be published.
9. Rothenberger DA, et al: Blunt maternal trauma: a review of 103 cases. *J Trauma* 18:173-179, 1978.
10. Eddy VA, Morris JA, Rozycki GS: Trauma and pregnancy, in Ivatury RR, Cayten CG (eds): *The Textbook of Penetrating Trauma*. Philadelphia, Williams and Wilkins, 1996, pp 695-701.
11. Pearlman MD, Tintinalli JE, Lorenz RP: Blunt trauma during pregnancy. *N Engl J Med* 323:1609-1613, 1990.
12. Bracken MB, Shepard MJ, Collins WF, et al: A randomized, controlled trial of methylprednisolone or naloxone in the treatment of acute spinal cord injury. *N Engl J Med* 322:1405-1411, 1990.
13. Neufeld JDG, Moore EE, Marx JA, et al: Trauma in pregnancy. *Emerg Med Clin N Am* 5:623-640, 1987.
14. Rolbin SH, Levinson G, Shnider SM, et al: Dopamine treatment of spinal hypotension decreases uterine blood flow in the pregnant ewe. *Anesthesiology* 51:36-40, 1979.
15. Gilson GJ, Miller AC, Clevenger FW, et al: Acute spinal cord injury and neurogenic shock in pregnancy. *Obstet Gynecol Surv* 50:556-560, 1995.
16. Head H, Reddoch J: The autonomic bladder, excessive sweating, and similar other reflex conditions in gross injuries of the spinal cord. *Brain* 40:188, 1917.
17. McGregor JA, Meeuwse J: Autonomic hyperreflexia: a mortal danger for spinal cord-damaged women in labor. *Am J Obstet Gynecol* 151:330-333, 1985.

Vanderbilt Morning Report

Low Back Pain with Progressive Weakness: A Case of Cauda Equina Syndrome from Lumbar Disc Herniation

Case Report

A 65-year-old white man came to the Vanderbilt Internal Medicine Clinic complaining of low back pain and progressive weakness. The low back pain began two to three weeks earlier, without obvious precipitating mechanical injury. A chiropractor made adjustments on two occasions, but x-rays taken at the chiropractor's office were negative by the patient's report. Ten days before presentation he noted some leg weakness, worsening pain with radiation down both legs, and inability to walk without assistance, and one week prior to admission he presented to a local emergency department (ED) with pubic pain and inability to urinate. He was catheterized (in and out) and given antibiotics for prostatitis, but the following day he returned to the ED where a permanent Foley catheter was placed. He entered the clinic in a wheelchair with the Foley catheter in place. His past medical history showed a myocardial infarction in the early 1970s (25 years previously) and an unspecified cardiac arrhythmia treated with quinidine since the late 1970s. He had stopped smoking cigarettes in the 1970s, and he was otherwise healthy. His medications included an antibiotic and quinidine. The vital signs included temperature 98.3°F, pulse 101/min, respiratory rate 20/min, and blood pressure 160/100 mm Hg. The directed physical examination revealed a well-nourished man sitting in a wheelchair and in no acute distress. There was no tenderness to palpation along the thoracic or lumbar spine. His mental status appeared normal. His upper extremities had normal strength, sensation and reflexes, and his cranial nerves were intact. Lower extremity examination revealed 4/5 bilateral hip flexor and knee extensor strength, and 0-1/5 strength of the ankle flexors and extensors bilaterally. Patellar reflex was 1+ on the left and 3+ on the right. Sensory examination was normal below the knees, but he had decreased light touch and pin prick sensation on the anterior thighs and perianal region. An emergency MRI (requiring general anesthesia because of severe back pain) revealed a large symmetric disc

herniation at the L3-4 level. A diagnosis of cauda equina syndrome was established, and emergency surgery was performed the same day.

Discussion

The cauda equina begins around the first lumbar vertebra in adults, and consists of the lumbar and sacral anterior and dorsal nerve roots contained in the thecal sac. They traverse the spinal canal distally, exiting via the neural foramina at the appropriate level. All of these nerve roots are in close proximity and are therefore prone to collective injury. The cauda equina nerve roots carry the sensory and motor innervation for the major portion of the lower extremities, the pelvic floor, and the sphincters. They are also responsible for autonomic innervation of these areas, including bowel and bladder control.

Injury to the cauda equina is usually caused by compression, most commonly by spinal neoplasms, specifically ependymomas. Schwannomas and metastatic disease can also occur, while lipomas and teratomas are much more rare. Nonneoplastic compression can result from spinal stenosis or herniated lumbosacral discs. Most (90%) herniated discs occur at either L4-5 or L5-S1, while the L3-4 disc (as in our patient) accounts for only 2% to 5% of all herniations.¹ Herniation most commonly occurs in the posterolateral direction, resulting in single nerve root compression. A large centromedial herniation must occur to compress the cauda equina. Noncompressive causes include spinal arachnoiditis, epidural abscess, or ischemia.

The symptomatology of the cauda equina syndrome results from dysfunction of the various components of the lumbar and sacral nerve roots, and usually consists of low back pain, saddle anesthesia, sphincter dysfunction, and motor weakness. Neurologic findings are not confined to a single nerve root, are usually bilateral, and may be asymmetric. Urinary incontinence is a consequence of retention with overflow leakage. Fecal incontinence results from loss of rectal sphincter tone. Bilateral sciatica is a distinguishing feature of cauda equina compression resulting from lumbar disc herniation.

Presented by Anderson Spickard III, MD, assistant professor of medicine, and Jeannine Z. P. Engel MD, primary care chief medical resident, Vanderbilt University Medical Center, Nashville.

The treatment of the cauda equina syndrome, regardless of etiology, is surgical decompression. Removal of the offending material must be done as soon as possible after symptoms begin. One study² looked retrospectively at 14 patients with cauda equina syndrome from lumbar disc herniation. All cases were from a single major medical center, and all patients received similar surgical intervention. Most herniations occurred at L4-5, followed by L5-S1 and L3-4. All but one patient had urinary incontinence in addition to other presenting symptoms. The time to surgery was less than 48 hours in seven patients (early intervention) and ranged from three days to one month in the other seven (delayed intervention). When outcomes were measured at six months to three years after surgery, all of the patients in the early intervention group had only residual low back pain, or were completely normal. Of the seven patients with delayed therapy, two were normal, four had residual incontinence or impotence, and four had residual weakness or numbness. The cauda equina syndrome, like epidural abscess and other cord compression syndromes, should be considered a surgical emergency.

This case raises one interesting question. Does chiropractic manipulation lead to lumbar disc herniation or cauda equina syndrome? Information in the medical literature is confined to one review article. Haldeman and Rubinstein³ reviewed the literature from 1911 to 1989 and found ten reported cases of cauda equina syndrome in patients having had spinal manipulation without anesthesia. The authors attempted, but failed, to find additional cases from discussion with local surgeons, chiropractic colleges, and practicing chiropractors. A prospective evaluation of 2,000 patients treated at a chiropractic college revealed no major complications. Finally, their review of malpractice cases against chiropractors revealed only three additional cases. They concluded, therefore, that cauda equina syndrome is an extremely rare complication of chiropractic manipulation. □

References

1. Jaradeh S: Cauda equina syndrome: a neurologist's perspective. *Reg Anaesth* 18(6S):473-480, 1993.
2. Shapiro S: Cauda equina syndrome secondary to lumbar disc herniation. *Neurosurgery* 32:743-747, 1993.
3. Haldeman S, Rubinstein SM: Cauda equina syndrome in patients undergoing spinal manipulation of the lumbar spine. *Spine* 17:1469-1473, 1992.

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TMA Alliance Report

Accomplishments of a Healthy Organization

After the AMAA Annual Convention in Chicago in June, members of the TMA Alliance should be holding their heads high. Many of our year-long efforts were recognized and applauded. Because our motto is "Physicians' spouses dedicated to the health of America," we were especially proud to receive the HAP (Health Awareness Promotion) award for a medical society and alliance-sponsored Health Education Project. The combined efforts of the Chattanooga-Hamilton County and the Bradley County Medical Society Alliances sponsored the "Living With the Enemy" photo exhibit depicting the horrors of domestic abuse. The project was organized and directed by Connie Stohler of Chattanooga and Vanessa Clark of Cleveland. The alliances also invited Denise Brown, sister of Nicole Brown Simpson, to keynote a public forum on the photo exhibit's opening day. This project was well publicized, and the events were well attended.

Our TMA Alliance also received national recognition in the area of membership. The Overton County Medical Society Alliance was recognized as a newly federated county alliance. To this new member of our TMA Alliance family we say, "Congratulations and welcome aboard!" Our good wishes to Helen Weissinger, president for 1996-97, and to all who join this group.

Also in the area of membership, we had six county alliances receiving awards for substantial increases in membership: Henry-Carroll with 122%, Lakeway (Grainger, Hamblen, Hancock, Jefferson) with 500% (WOW!), Northwest (Dyer, Lauderdale) with 110%, Obion with 145%, Rutherford/Stones River (Canon) with 113%, and West Tennessee Consolidated (Carroll, Chester, Crockett, Fayette, Gibson, Hardeman, Haywood, Henderson, McNairy, Madison) with 109%. We value our members and look upon our membership as a source of personal support, a means of sharing concerns about medical issues, and an instrument for promoting better health in our communities.

We received awards in the areas of health promotions and membership, but that's not all! For the 11th consecutive year, the TMAA made the greatest contribution to AMA-ERF of any state. Three Tennessee county alliances—Hamilton, Knox, and Shelby—received awards for the greatest contributions by counties. The total contribution from Tennessee for 1995-96 was \$187,701. Why do we repeatedly support AMA-ERF in such a grand manner? Is it simply because it's such a worthy cause, and we're generous and good-hearted? Is it our pride in our medical schools, or is it because of the cooperative efforts between physicians and our universities? Yes—to all of the above!

And just in case we haven't tooted our horn sufficiently, we have another matter to crow about. Our own Johnnie Amonette of Memphis is president-elect of the AMA Alliance for 1996-97. So get ready for a special reception in her honor at next year's annual convention when she becomes president!

In her inaugural address, Sandra Mitchell, AMAA president for 1996-97, stated that her primary focus during this next year will be expanding and strengthening the Alliance's SAVE (Stop America's Violence Everywhere) initiative. Mitchell said that the greatest gain from her alliance involvement has been the

amount of education she has received, and the ability to translate it into community action. In addition to the many SAVE projects already planned, she encouraged local medical societies and alliances to join in an effort to unite the medical community in its fight against violence and abuse in a campaign called SAVE-A-SHELTER. Beginning on Oct. 9, 1996, physicians and their spouses are urged to adopt an abuse shelter, transition home, rape crisis center, or other establishment serving victims and their children.

Concerning another emphasis during her year as president, Mitchell says, "I'm trying to encourage the 'family of medicine' concept—that the issues affecting the AMA are the same ones that affect physician spouses. What our members do best is take the initiatives and concerns of the AMA and put those into action in the community. There's a wonderful alliance between medical societies and alliances. They approach issues from their professional view, and the alliances look at the issues as an action program to take to the community and make the initiatives happen." Through this cooperative effort, we can accomplish much within our family of medicine, as well as in our communities.

Mary Morgan
TMAA Health Promotions Chairman

Letters to the Editor

There Are Better Ways To Help These Children

To the Editor:

Your editorial comments about mental health "consumers" prompts me to comment. *I liked what you said and the way that you said it.* In your editorial you asked, "tell me how one consumes mental health . . . Who is this mental health consumer, and how does she do it? Does she suck it vampire-like out of her charge? . . . For her to consume it she must have a supplier."

Now for a comment about my own perspective. Along with many other professionals, I believe mental problems and physical problems are intimately related. The brain isn't segregated in a bony box on top of one's body. Instead, it's connected to all other parts including the gastrointestinal system.

Many children today are troubled by "mental" symptoms including the attention deficit/hyperactivity disorder. The most popular current treatment espoused by professions features medication—especially Ritalin. Too often diet is ignored even though many reports in the peer-reviewed journals document the diet behavior relationship.

If an automobile jumps and jerks, gets only about six miles to a gallon of gasoline and puts out blue smoke, wouldn't you check on the type of fuel in the gas tank? The same principle should hold true in helping children who are mental health "consumers."

Readers of *Tennessee Medicine* who would like additional information can obtain it from the IRS-approved International Health Foundation, P.O. Box 3494, Jackson, TN 38303-3494.

William G. Crook, MD
680 W. Forest Ave.
Jackson, TN 38301

1. Thomison JB: On providing and consuming. *Tenn Med* 89:231, 1996.

In Memoriam

Thomas Kelly Ballard Jr., age 76. Died July 9, 1996. Graduate of University of Tennessee College of Medicine. Member of Consolidated Medical Assembly of West Tennessee.

Harry Cowan Moss Jr., age 71. Died July 6, 1996. Graduate of University of Tennessee College of Medicine. Member of Washington-Unicoi-Johnson County Medical Association.

Paul Elliot Perlman, age 46. Died June 22, 1996. Graduate of State University of New York College of Medicine. Member of Sullivan County Medical Society.

CORRECTION

In the July issue of *Tennessee Medicine*, where we reported the death of James T. Hayes, we incorrectly listed his medical school. Dr. Hayes graduated from the University of Tennessee College of Medicine.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

BLOUNT COUNTY MEDICAL SOCIETY

Daniel W. Cotten, MD, Maryville

NASHVILLE ACADEMY OF MEDICINE

Phillip H. Bourne, MD, Nashville

Denise M. Buntin, MD, Hermitage

Francis B. Dove Jr., MD, Nashville

Cornelia R. Graves, MD, Nashville

Richard C. Huddleston, MD, Nashville

Meredith R. Lentz, MD, Nashville

Gary D. Olbrich, MD, Nashville

William O. Richards, MD, Nashville
L. Anderson Walker III, MD, Nashville
Craig Wierum, MD, Nashville

SULLIVAN COUNTY MEDICAL SOCIETY

Stephen P. Combs, MD, Kingsport

Gamal S. Eskander, MD, Sparta

Darlene B. Litton, MD, Kingsport

Duc Q. Vu, MD, Kingsport

Board of Medical Examiners

Minutes - June, 1996

Name: John Aunins, MD (Wichita, KS)

Violation: Disciplinary action taken by another state.

Action: License suspended pending reinstatement in Kansas.

Name: Gabriel O. Itaro, MD (Chattanooga)

Violation: Unprofessional, dishonorable, or unethical conduct; gross malpractice or a pattern of continued or repeated malpractice, ignorance, negligence, or incompetence in the course of medical practice; making false statements or representations or being guilty of fraud and deceit in the practice of medicine.

Action: Per agreed order, license revoked.

Name: Yutaka Kato, MD (Atlanta, GA)

Violation: A pattern of continued ignorance, negligence, or incompetence in the course of medical practice.

Action: License restricted, prohibited from the personal use of diagnostic fluoroscopy in any manner; license placed on probation for two years; must obtain 100 hours of continuing medical education credits within the next two years; assessed civil penalties totalling \$8,000.

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during June, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Harry Baer, MD, Nashville

Lana S. Beavers, MD, Shelbyville

Raymond M. Brewer, MD, Collierville

Edward P. Caldwell, MD, Memphis

Jill F. Chambers, MD, Nashville

John E. Chapman, MD, Nashville

Richard C. Cole, MD, Decherd

Yvette G. Crabtree, MD, Nashville

Mark P. Freeman, MD, Brentwood

Chet M. Gentry, MD, Sparta

Bruce M. Gipson, MD, Shelbyville

Jean P. Gray, MD, Jackson

Joel T. Hargrove, MD, Columbia

Robert L. Harrington, MD, Dyersburg

James W. Jackson, MD, Dickson

Robert L. Jackson, MD, Memphis

Wayne Y. Kim, MD, Chattanooga

Michael D. Kropilak, MD, Knoxville

Anthony G. Lyon, MD, Knoxville

H. Lynn Magill, MD, Memphis

Joe M. Mazzolini, MD, Cleveland

James O. Miller, MD, Madison

John T. Moore, MD, Cookeville

Thomas F. O'Brien, MD, Memphis

Elsie P. Ollapally, MD, Madison

Michael L. Reeves, MD, Chattanooga

R. Henry Richards, MD, Bristol

Michael B. Seshul, MD, Nashville

Stanley S. Snow, MD, Nashville

David V. Willbanks, MD, Morristown

Jonathan D. Woody, MD, Chattanooga

David M. Ziebarth, MD, Cordova

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

Special Conferences/Seminars

Detailed brochures for the following courses are available. In some cases, registration numbers are limited.

- Oct. 18-19 Laryngeal Video Endostroboscopy Workshop
- Nov. 13-16 2nd Neonatology Symposium—Asheville, N.C.
- Dec. 6-7 22nd High Risk Obstetrics Seminar

For information contact Division of CME, Vanderbilt University School of Medicine, D-8211 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

Continuing Education Schedule

Memphis

- Oct. 4 Asthma Conference
- Oct. 4-5 College of Medicine Alumni Weekend
- Oct. 9-10 Loss Prevention Seminar—Johnson City
- Oct. 11 13th Forum on Child Health AIDS in Children: Update on Progress
- Oct. 29 Loss Prevention Seminar—Gatlinburg
- Nov. 1-2 15th Gynecological Surgery Seminar
- Nov. 4-8 Advances in Medicine—Maui, Hawaii
- Jan. 9-11 High Risk Perinatal Seminar
- Feb. 17-20 Update in Obstetrics & Gynecology—Grand Caymen Island
- Feb. 23-28 Clinical Medicine—Kauai, Hawaii
- March 6-8 Symposium on Critical Care & Emergency Medicine—Hot Springs, Ark.
- March 8-15 Current Issues in OB/GYN—Snowmass Village, Colo.
- March 16-22 30th Review Course for the Family Physician
- June 6-7 1997 General Surgery Update

Knoxville

- Oct. 11-12 Molecular Genetics—Clinical Applications for Primary Care

- Oct. 13-16 18th Obstetric Office Ultrasound Workshop
- Oct. 18-19 1st Pediatric Trauma Conference
- Oct. 28-30 16th Smoky Mountains Ob/Gyn Seminar—Gatlinburg
- Nov. 6-8 Advanced Cardiac Life Support Course
- Nov. 15-16 New Concepts in the Treatment of Cardiac Disorders
- Dec. 3-5 Perinatal Update '96—Gatlinburg
- April 23-25 20th Family Practice Update & Review—Gatlinburg
- June 6-10 13th Alzheimer's Disease Symposium—Gatlinburg
- June 12-14 42nd Great Smoky Mountains Pediatric Seminar—Gatlinburg

Chattanooga

- Oct. 17-18 Aging Patient
- Oct. 26 Evaluation and Management/Chart Documentation
- Dec. 5-6 Cardiology
- March 7-8 Allergy & Immunology
- March 20-21 Pediatrics
- June 18-21 Family Medicine

For information contact Mrs. Jean Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163, Tel. (901) 448-5547.

Meharry Medical College

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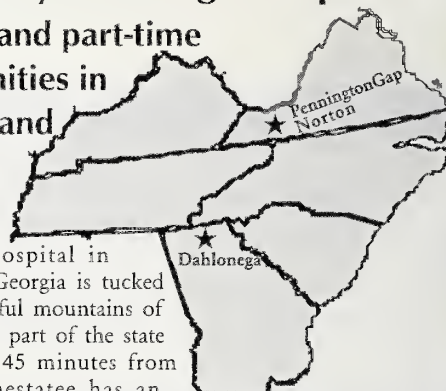
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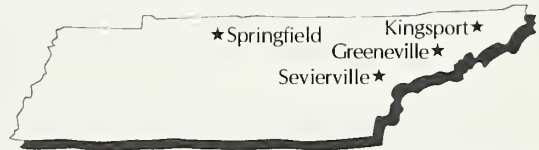
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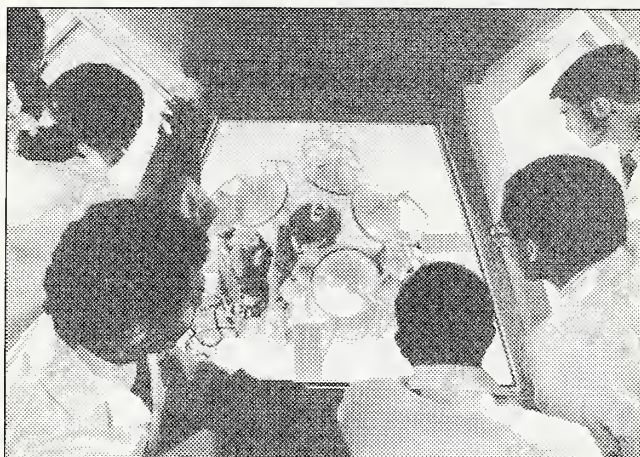
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List of Advertisers

Airborne Express	323
Astra Merck	347
Boatmen's Trust	326, 327
Carolyn Avery & Associates, Inc.	343
Dodson Insurance Group	325
DuPont Pharma	332
Emergency Coverage Corporation	344
First Tennessee Bank	310
Jeremy Cay, Edisto Island	314
Nashville Neuro-Pain Corporation	331
Pfizer Laboratories	312
Rural Health Services Consortium	344
Spectrum Healthcare Services	345
State Volunteer Mutual Insurance Company	348
Sterling Healthcare Group	344
Team Health	344, 345
TN Dept. of Mental Health/Mental Retardation	340
The TMA Association Insurance Agency, Inc.	334
U.S. Air Force Reserve	318
U.S. Army	346
U.S. Army Reserve	339
Witt/Kieffer	344

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Richard M. Pearson, MD

Emperors and Empires

In 122 A.D. the Roman emperor Hadrian commissioned a wall to be built completely across the island of Britain. The ostensible reason was to protect the Britons who were loyal to the Romans from the "barbaric" Picts and Scots to the North. The real reason was to protect the business interests of the empire in Rome, far from the wall, but the emperor wanted the locals to think that he had taken a special interest in their personal welfare. Of course the Roman consuls and governors and centurions all knew that they were protecting Rome, but they told the soldiers in the trenches that their mission was to protect the local citizens.

In A.D. 1996 the U.S. stock market experienced a major downturn. The valuation of the largest investor-owned HMO in the United States declined by 34% in the course of a few days. Other HMOs experienced similar major declines, and the profits of this corporate empire are now threatened by events in the real world. Suddenly the marketplace is threatened by "barbarians from the North." The ostensible purpose of all these empires is to provide quality health care to millions of average citizens who don't keep track of Wall Street and who would be surprised to learn that a downturn in the Market would directly affect what happens to them when they get sick. The real purpose of these empires, supported by corporate prelates and benefit-manager centurions, is to shuttle billions of dollars in corporate profits back to the "center of the known world" where the CEO Caesars live and where the shareholder *Senatus populusque corporati* hold annual meetings. CEO annual salaries will fall if the Caesars don't keep the shareholders pumped full of dollars.

How does the emperor keep everyone happy back at home? He builds a "wall" out in the hinterlands. He tells all the patients that the "wall" is being built to help and protect them. He hopes everyone will feel warm fuzzies for the emperor and the empire. The "wall" is built out of new quality assurance directives, increased utilization review, decreased benefits, narrowed formularies, and decreased reimbursement to the soldiers—in this case the physicians who are actually providing the care.

What happened to Hadrian's wall? It eventually fell down when the people outside the wall, the people inside the wall, and the soldiers on the wall realized that they had more in common with each other than with the powers back in Rome. Together they all built a new society that benefited their unique interests and didn't pay homage to the emperor.

The wall that investor-driven for-profit managed care companies build between physicians and their patients will eventually fall down. Patients know when they are getting good care and when they are getting "emperial" care. Eventually patients inside the system and patients outside the system will unite with informed, empowered, caring doctors and tear down the walls in order to restore "care" to "health."

R. Pearson MD



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John B. Thomison, MD

Stroke

This issue of *Tennessee Medicine* marks the beginning of a new series of articles that is unique in that unlike most of the other series appearing here we can see the end from the beginning. The series, opening with a paper by Howard Kirshner, MD, entitled "Medical Revolution: The Prevention and Treatment of Stroke, 1996, Part 1," will comprise, so we have been informed, 12 articles, and no more, having to do with stroke. Since no article is accepted until it is in hand and reviewed, there of course remains the possibility of a lesser number, but if the quality of this first article is maintained, and there is every reason to think it will be, you will be treated to the full series, which will be contributed by some of Tennessee's most outstanding neurologists and neurosurgeons.

Though stroke manifests itself in the central nervous system, and for treatment purposes falls in the domain of these specialists, its basis lies in the cardiovascular system. It is not surprising, then, that the American Heart Association, a leader in the area of cardiovascular disease, should have added stroke to its mission, as it did a number of years ago.

Tennessee consistently ranks among the top five states in disability and death due to stroke. In January of 1995, therefore, the Tennessee Affiliate of the American Heart Association launched a stroke initiative program by organizing a task force comprising physicians, including specialists from academic institutions, pharmaceutical representatives, and government officials, to develop initiatives that would reduce the devastating effects of stroke in Tennessee. The work of this task force has resulted in many successful programs that have benefitted stroke patients, caregivers, and medical professionals, programs that have included educational symposia for doctors and nurses, distribution of stroke-specific information to patients, and organization of stroke support groups and stroke conferences for both patients and caregivers. June 1996 was designated by the Governor as Stroke Month. It coincided fortuitously with the release by the FDA of tissue-type plasminogen activator (tPA) for use intravenously in the treatment of early ischemic stroke, thus, as Dr. Kirshner says, officially opening the era of acute therapeutic intervention in stroke.

A task force subcommittee dedicated to medical education was also organized to ensure that medical professionals were made knowledgeable of the latest developments in prevention and treatment of stroke. This eventuated in the series of the 12 articles on stroke that are to be published in this journal, with the expectation of mitigating the heavy burden of death and disability from this devastating disease.

IMPACT!!!

In case there is some one or another of you out there who may be ignorant of the facts of the matter, the IMPACT to which I refer here is not, even though it has more than a tangential relationship with, the word *impact*. It is in fact simply an acronym formed of the first letters of **I**ndependent **M**edicine's **P**olitical **A**ction **C**ommittee—**T**ennessee. It is our hope that IMPACT will make a powerful impression itself, one of the definitions of the real word "impact." Its choice as the name of our political action committee (PAC) was obviously more than coincidental, even if the similarity is no more than fortuitous.

The Board of IMPACT, and those of us who are contributors to it, believe that its impact is important, even though each of us must inevitably on occasion disagree with some of its choices. We have always to keep in mind that in the democratic process there is likely never any such thing as unanimity, and any expectation that any candidate will meet all of our expectations is pure delusion. All of us have many priorities, and some of them will occasionally be in conflict.

IMPACT has to do with medicine, and its objective is to elect individuals who are sympathetic toward our *medical* goals. As individuals, we hope, of course, that the views of our medically friendly candidate will also be economically sound (in our own estimation), and that he will view our other pets with, if not enthusiasm, at least tolerance.

It is hard for the politically naive (which *of course* describes neither you nor me, but almost everyone else), to sort out all the options, and to be familiar with the record of every one of the myriad seekers of our votes (and just incidentally money). That is where IMPACT comes in. Its board and staff are more politically sophisticated than certainly I am, and perhaps you as well, and have more informed contacts, and are thus in a better position to apportion funds appropriately.

I know there are among you those who disagree on principle with the whole concept of PACs, and in the best of all possible worlds I would, too. On the other hand, the best of all political climates is not the sort in which we live. It may not be the worst of all possible worlds, at least not yet, but there are times it seems well on its way. Too, you and I may disagree fundamentally on certain issues as to their place in the medical milieu. In truth, I view PACs as the next thing to an abomination before the Lord. Nevertheless, when I look at the vast amounts of money charlatans and worse are bringing to bear against us and our patients, I am moved to action—at least, action of sorts.

Fully recognizing that some of my contributed funds may go to support a candidate or so that is abhorrent to me, and so cancel out some of my private contributions, the action I was moved to take in this critical—or what I at least view as critical—election year was to upgrade my membership from Sustaining to the Governor's Club. But then, to coin a phrase, politics makes strange bedfellows. A variety of activities can take place in that venue, some of them salubrious. On the other hand, some others of them may not be, and in that unhappy situation the PAC will gladly function as one's surrogate.

I hope you will likewise be so moved.

Med School Revisited: 1941 to '44— And so on to 1996 and Beyond

Tim Sewell's thoughtful, well-crafted article about the medical students of today, carried elsewhere in this issue, brought back a flood of generally disorganized memories about my "good ol' days" that weren't always, or anyway not necessarily. The oldest current faculty member to get his two bits into the article is Jim Hunt, who is in a younger generation than I by virtue of our being separated by the Second World War, which was a great divider in a number of ways, even though some of the medical students I taught beginning in 1949, the year he matriculated, were my age or even some years my senior. Though I know that a generation is technically 40 years, sometimes cataclysmic events jam them up closer together. Thus the previous generation-divider was The Depression, which began when I was in the second grade, and whose effects were still being felt when I started college in 1938, which was when the other shoe dropped in Europe. If you place The Depression and the First and Second World Wars all in the same generation, which technically they were, then that generation had a real run of bad luck. If one happened to have missed the First World War, well, try Korea at the other end.

I'll let the historians worry about that, and say only that my own personal generation is thus far 75 years long and has included The Depression, the Second World War, the Korean War, Vietnam (my children's war), the Cold War, and assorted scattered more recent hot little (or not so little, depending on the extent of your own personal involvement) military actions. And you can now add international terrorism. Modern communications and logistics are steadily increasing the difficulty of containing any sort of event.

All of that has, of course, had its effect on medicine and its practitioners, which is why it is difficult to compare generations of students or doctors. Besides my classmates, during my nearly two decades of teaching in the Pathology Department at the Vanderbilt Medical School I had very close contact with a lot of second year students, and more superficial contact with a great many more. A relatively small percentage of my close contacts I have followed in varying relationships for up to 40 or more years. One develops impressions about where the profession is headed, and that impression is being continually updated. One tends to hear, not to mention make, often gratuitously, such blanket statements as, "The young doctors these days seem to . . . (or don't seem to . . .) whatever, and then we compare them to the good, or at least the better, we think, old days.

Keep in mind that you are reading the recollections of one observer's experience more than 50 years after the fact in one University. I started my medical career, in which I include pre-med, in 1938 when I came to Vanderbilt as a college freshman. My interest in medicine had been lifelong, if one can consider 15 or so years lifelong, and strongly fostered by our family doctor and a number of doctors in the family. Despite this, it is my distinct impression, which I share with some of the current and past faculty members, that the students I taught were more serious minded than my classmates and I were, at least when we entered medical school, and were better prepared to live in and care for a fractured world, one that most of us I think failed to perceive as such. Possibly that was partly because almost none of the students in those days had families, as they did after the war, a situation that can mature one pretty quickly.

On Sunday, Dec. 7, 1941 all of that was drastically and dramatically changed. My classmates and I had been suffering all the pangs described by the students Mr. Sewell interviewed, but those pangs suddenly became little more than minor annoyances. Two of our classmates, who had reserve line commissions in the Navy, permanently disappeared from our midst, and most of us who remained were faced with voracious draft boards that were clamoring for warm bodies with little regard for academic status. Students who depended on summer jobs to help pay their way found that avenue blocked by the suspension of vacations for the duration. Those of us who lived away from Nashville found buses and trains clogged with inductees and military personnel from Camp Forrest in Winchester and Fort Oglethorpe in Chattanooga. Gasoline and tires were in short supply for civilians, and rationing was quickly imposed. The mechanism for that was already in place, since the Japanese surprise attack on Pearl Harbor and other U.S. military installations in the Pacific simply precipitated what most citizens had for some time seen as inevitable. Its effect was to solidify public opinion, which had sometimes been on shaky ground, behind the Allies. Marriages began to flourish, particularly after we went on active duty in either the Army's ASTP or the Navy's V-12 program in the middle of our third year, and began receiving the magnificent sum of \$54 a month plus room and board and clothing.

We graduated on Sept. 11, 1944, in the darkest days of the war, midway between D-Day and the Battle of the Bulge and Bastogne, and were prepared to be in the thick of the fighting in one theater or the other by the end of our nine-month's internship the next summer. Things moved at least as quickly during those nine months, though, as they have in any similar period of our history. In April Hitler's war machine ran out of steam, and only a little more than a month after I went on active duty as a medical officer, the Japanese surrendered unconditionally. Two years and three months later I arrived in Chattanooga with a wife and child to start a residency in surgery, which after something less than two years turned into pathology back at Vanderbilt.

Predictably, the young doctors of today are a product of their times, just as we were. And times change—generally by slow, quiet evolution, but sometimes, of course, by revolution, such as when a war, economic calamity, natural disaster, or adverse governmental fiat get dropped in. When I was a student there was not a lot of money to be made anywhere in medicine, and there was little of that aspect in choosing a medical practice that I ever heard discussed among my contemporaries. Most practices were solo or in small groups with senior and junior partners. After the war began during our first semester of medical school and marriages began to pick up, the better residencies still continued demanding that residents be unmarried, since

they were expected to devote pretty much all of their energy to their work. That tradition died hard, and slowly, and the death blow was not dealt it until returning veterans with families began entering medical school and residencies. Young medical graduates began expecting to be allowed more time with their families, and group practice began to take shape as the norm, fueled more recently by other considerations, some financial and some otherwise.

As the income discrepancy between the "thinkin' " doctors and the "cuttin' " doctors grew, as it also did between subspecialties in both groups, government agencies, business, especially HMOs, MCOs, and the hospitals, as well as the public generally, began using it as a wedge to foment discontent and jealousy within the profession, and doctors within the high-income subspecialties were often accused, sometimes from within the profession itself, of having chosen their specialty simply for the money.

Individuals have different desires and expectations that extend to their work, their family life, and their leisure time, in short, from their expectations in life, liberty, and pursuit of happiness. Motivations are hard to define in one's own self if one is honest, and therefore impossible to judge in another. We attempt it at our peril. Nonetheless, it is routinely done with abandon on all fronts. Judging from externals is fraught with hazard at best. One man's just reward is another man's greed.

I have been disheartened in recent years by what I have seen on the road ahead in my foggy crystal ball. The doctors are no longer the providers of health care, so called by the bureaucrats. The providers are the business entities that travel under various labels. Perhaps they would more appropriately be designated "purveyors," which my dictionary defines as "one that promulgates something: *a purveyor of lies*." That is, of course, simply its illustration. What doctors do is take care of people, people who are called not clients or consumers, but patients. I'm haunted continually by the fear I may have to depend upon some so-designated purveyor of so-called health care to be the provider of my own Medicare care. Gracious God, please forbid.

The bright spot in all this is where it has always been: the *doctors*. We have allowed the bureaucrats to confuse the picture. There are physicians and there are surgeons; all together they are doctors. Physician and doctor are not synonymous, although the more recent editions of the dictionaries have made them that way. You and I know that those who promoted referring to doctors of medicine as physicians, and that includes the AMA, did so because everybody and his sister wants to be called doctor nowadays. The public, though, is not fooled. They know who their doctor is. Their doctor is the one who meets their medical needs, the one whose patients they are. That person they refer to not as "my physician," but as "my doctor." Listen, and see if that isn't so. If that person happens to be a chiropractor or a naturopath, or some such, well, maybe that is partly our fault. Maybe it all is. Maybe we should have held our public's hands more, and spoken more softly in their ears. Such is, after all, in the best Hippocratic tradition.

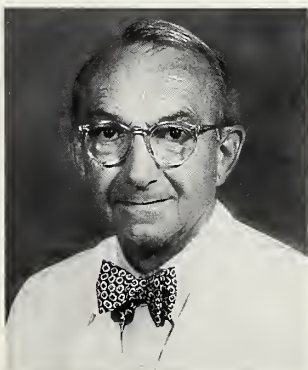
I don't get a chance to spend time with medical students anymore. What I do see is young doctors, and I see much that is wrong. But what I see wrong with the way these young doctors practice is traceable almost exclusively to a seriously flawed system, and not to the doctors or their aspirations or their commitment. I am comforted by what I read that others have seen in the medical students of today, which are the same things that have always been there: a desire to take the best care possible of the people who have entrusted them with their lives. I also have enough faith in the American people to believe that though things may get worse before they get better, those people are going to see through all the garbage in the capitols of this nation, and eventually set things right. The downside is that some of us may not live to see it.

But then, as the Marine sergeant shouted on the Normandy Beach, "Come on, you bastards! Do ya wanna live forever?" (I have it on good authority that whatever the shouted retort, the heartfelt prayer of every one of them was, "But please, Lord: at least a little longer!") I think that though the same prayer might not be on the lips of every last one of our patients, their doctor generally knows which ones those are. Except for a scattered few of our colleagues, the likes of which have always been around to be a blot on our escutcheon, today's doctors are trying their level best, just as yesterday's did, to give them that small edge, and as much more as possible. □

Students: Fulfilling the Dream

Tim Sewell

"I think most young people who are coming into medicine are coming for the same reasons. They're bright and they're looking for a stimulating education and a stimulating professional career. Most of them are still interested in serving people. That doesn't change."



Hershel P. Wall, MD
UT Memphis

In August, Margaret Hoglan Taylor embarked on a lifelong dream when she entered medical school at the University of Tennessee, Memphis.

Taylor, a program management advisor at Federal Express Corp., is not the traditional first-year medical student. She admits to being "past 40" and she holds an undergraduate degree in comparative literature and a master's degree in business administration. Still, when it comes to doubts, uncertainties, and expectations, she has a great deal in common with her younger classmates.

"I'm petrified," Taylor says. "I've heard so much about how medical school consumes your life 24 hours a day, seven days a week. I have to ask myself, 'Can I handle it?'"

That's a question that's asked at one time or another by almost every first-year medical student, according to officials at UT Memphis. James C. Hunt, MD, University Distinguished Professor and former UT Memphis chancellor, says students had the same doubts and concerns in 1949, the year he entered medical school at Bowman Gray University.

"I don't think there are

any striking differences in that regard between the students of that time and the students of today," Hunt says. "If anything, today's students come in far more informed than I was when I entered medical school. For that matter, they're far more informed than the average student that came in 10 years ago. By and large, they're broader, better-prepared, and more discerning, and they have higher expectations."

Taylor says she isn't sure what to expect from her first year of medical school, but after spending the past two years working a full-time job and taking pre-med courses in her spare time, Taylor says she is ready to get started on her medical education.

"I've always wanted to be a doctor," Taylor says. "But when it was time for me to go to college, a career in medicine didn't seem like an option. We were not well-to-do; my father was a minister and there were five kids in the family."

"I don't want to leave the impression that my parents wouldn't have helped me or that they discouraged me in any way," Taylor adds. "But back then we didn't know about grants and student loans. We thought that you either saved for college or you worked your way through. Medical school didn't seem possible."

Taylor attended undergraduate school at the University of Memphis in the mid-1970s. She made a career for herself in the business world, and in 1983 she earned her MBA from the University of Memphis.

"I've enjoyed my career in business, but I've always found myself saying, 'I can do more than this,'" Taylor says. "I finally reached the point where I was crazy enough to try this."

In order to reduce the cost of her medical education, Taylor is one of 22 first-year students taking part in the university's Underserved Areas Clinical Scholars Program, a program designed to increase the number of family physicians in rural and underserved areas. Under the terms of the program, UT Memphis will receive \$20,000 per year from Taylor's sponsor, Fort Sanders Health System. In return, Taylor has agreed to work one year in a community served by the Fort Sanders system for each year of sponsorship. Right now, Taylor is interested in specializing in obstetrics/gynecology and practicing in East Tennessee.

Because she is a participant in the Underserved Areas Clinical Scholars Program, Taylor may be able to escape the burden of student loan debt incurred by many medical school graduates. But, she realizes that she and her husband, Bob,

Mr. Sewell is a reporter for the Memphis Business Journal and writes frequently for the Memphis Health Care News.

will have to make some financial sacrifices in order for her to pursue her dream of becoming a doctor.

"My husband—the one person in the world who could've talked me out of doing this—has been so supportive," Taylor says. "I'm in my prime earning years and I'm going to put us back into student poverty."

As a business person, Taylor is familiar with the changes in medicine being wrought by managed care, and she is aware that her chosen profession may not be as financially lucrative in the early years of the 21st century. "I realize that the economic landscape of medicine is changing dramatically," Taylor says.

"Several physicians have told me that they understand my desire to get into medicine, but they've also told me that this is a terrible time to go into medicine," Taylor adds. "They've warned me that the financial rewards won't be as great, but that doesn't really bother me. I'm not doing this for the money. If money was my motivation, I'd stay in business and continue to work my way up the corporate ladder."

Eric Hutchins, a second-year medical student at UT Memphis, more closely fits the expected profile of the "average" medical student. At 22, Hutchins has a degree in chemistry from Freed Hardeman University. He says he didn't decide to become a doctor until his senior year at Freed-Hardeman.

"I always enjoyed science. But in college I realized that I didn't want to spend my life working in a lab," Hutchins says. "I realized then that I wanted to become a doctor."

Like Taylor, Hutchins is a participant in the Underserved Areas Clinical Scholars Program, and is being sponsored by the Baptist Memorial Health Care System. After his residency, he hopes to practice primary care in one of the rural hospitals within the Baptist system.

"I already wanted to go into primary care, so this program was perfect for me," Hutchins says. "I'll still have some minimal loans to pay back, but I won't owe as much as I would have otherwise."

Hutchins says he can sympathize with first-year students like Taylor who are somewhat apprehensive about the workload. "I remember that in my first year I was scared when I was told about all the work we'd have to do," Hutchins says. "But I was also very curious—and nervous—about what the administrators and the teachers would be like. I survived

"A number of people think that students are less idealistic when they graduate than when they come in. I don't think that's the case."



James C. Hunt, MD
Former UT Memphis Chancellor

that first year, and my grades ended up being better than what I originally expected."

As a second-year medical student, Hutchins faces pretty much a continuation of his first year—a great deal of classroom work and minimal exposure to patients.

"We do get to learn the basics of taking a patient history and performing a physical examination," Hutchins says. "I'm really looking forward to that. I recognize the importance of the classroom work, but I can't wait to begin working with patients."

As a second-year student, Hutchins also faces the prospect

of taking Part I of the National Board of Medical Examiner's Examination—the much dreaded licensing board examinations—next June. "I'm not worried about that at this point," Hutchins says. "And from what I understand, UT Memphis does a good job of preparing students for that."

After completing three more years of medical school and a three-year residency, Hutchins probably will begin his practice in 2002.

"I do wonder what medicine will be like then," Hutchins says. "It sometimes seems like it's a long way in the future. Other times, it seems like it will be here before I know it."

Rodney Beasley, 30, is a third-year student at UT Memphis. Like Hutchins, he says he is interested, though not necessarily worried, about what the nation's health care environment will look like in the opening years of the 21st century.

"Of course, I think about that," Beasley says. "But I never wanted to be a physician for the money. That was never the issue for me. In fact, I gave up two job opportunities that paid well over \$60,000 in order to come to medical school."

Like Taylor, Beasley entered medical school after spending several years in the workplace. Originally from Kansas City, Beasley received two undergraduate degrees—a bachelor of science degree in chemistry and a bachelor of arts degree in philosophy—in 1990 from Lincoln University in Jefferson City, Mo. He worked from 1988-1990 as a chemist for the Missouri Department of Health. From there, he went to Arkansas State University, where he earned his master of science degree in chemistry in 1993. Beasley entered medical school at UT Memphis in the fall of 1993.

Now in his third year, Beasley has overcome the hurdle of the state board examinations and he is beginning to think about what specialty he might like to pursue.

"When I entered medical school, I wanted to be a pediatrician," Beasley says. "Then I thought for a while about being a surgeon. Now I'm leaning toward med peds, a kind of cross between pediatrics and internal medicine."

Just as he has changed his mind regarding a chosen specialty, Beasley also has changed some of his ideas about medicine in general.

"My ideas about medicine have changed a lot," Beasley says. "I wanted to more or less work with people, and I didn't give a lot of thought to the body in general. I'm learning all that I need to know about the body, but the fun part still is working with people. That's really what I enjoy."

During his time in medical school, Beasley has managed to spend quite a lot of time with people. In fact, earlier this year, his involvement with community programs earned Beasley a community service award from the Tennessee Higher Education Commission. During the past two years, Beasley has participated in the Health Professionals Recruitment and Exposure Programs, a program that assists junior high and senior high students to prepare for college. He has also been active in the Minority Association for PreHealth Students, an organization that encourages high school students to consider careers in the biological sciences, and he has participated in the Memphis Teenage Sexuality Program, a program that addresses sexuality, pregnancy, and the prevention of sexually transmitted diseases.

"I work a lot with inner-city kids and they really look up to me. That gives me that extra boost of energy. It pushes me to work a little harder because I don't want to let them down. Like the average medical student, I still study six or seven hours a day. I may get less sleep, but it's worth it. Time management is the key," Beasley says.

Beasley says he realizes that his outside activities are helping to prepare him for his career. "It gives me an insight to the people that I'll be working with. Being a doctor is not just a status thing. We're supposed to be servers of the people and I think that this helps me to better serve in that role. Sometimes, if you get to know them in their environment, that can give you insight into their health problems and you can help them with that."

Beasley is scheduled to graduate in June 1998. He says he plans to stay in the Mid-South, practicing in either West Tennessee, East Arkansas, or Northwest Mississippi.

While money is not a big issue for Beasley, he says it is becoming more of an issue as he nears graduation. That's

because the student loans are beginning to pile up.

"I will admit that money is more of an issue now than it was before," Beasley says. "Now, I've got loans to pay back. That does concern me."

The repayment of student loans is an issue that concerns a large number of medical school graduates. According to officials at UT Memphis, the average debt load for graduating medical students is a little more than \$50,000.

"It might be a little more than that here," Beasley says. "I know of some students who owe \$70,000 and I've met some third-year students from private schools who are already \$120,000 in debt."

Curt Chaffin, 27, is a fourth-year medical student. Like Beasley, he has student loans to repay, but he says he has managed to keep his debt below the \$50,000 average.

"Since I'm on the lower end of the scale, that doesn't worry me as much as it does some other students I know," Chaffin says. "I have some friends who have taken out very large loans. Any time you have a loan like that, it creates a lot of stress."

Originally from Cleveland, Tenn., Chaffin received his undergraduate degree in engineering from Tennessee Technological University in 1993.

"... the financial rewards won't be as great, but that doesn't really bother me... If money was my motivation, I'd stay in business and continue to work my way up the corporate ladder."

Margaret Hoglan Taylor
First Year Medical Student

"When I entered college, I wasn't sure what I wanted to do. I went into engineering by default," Chaffin says. "Since then, I've learned that an engineering degree isn't so uncommon for medical students. There are 10 to 15 people in my class with engineering degrees."

Chaffin's father, David Chaffin, is a radiologist who now practices in Albany, Ky.

Chaffin has chosen to practice pediatrics. "My father is a physician, but that's not really what influenced my decision to become a doctor," Chaffin says. "I decided to go into pediatrics because I love kids. Kids have medical problems through no fault of their own. It seems like a lot of adults have helped cause their own illnesses through smoking, drinking, or some other lifestyle decisions."

Chaffin is scheduled to graduate on June 6. From there, he'll enter a three-year residency program. "I'm really looking forward to serving patients and being able to watch them grow and develop over time," Chaffin says. "There is a lot of uncertainty, though, and there is a fear there that's hard to shake. I think that's something that affects even those doctors who have been practicing for years."

As he begins his final year of medical school, Chaffin says he realizes that his ideas have changed. "My ideas and expectations of medicine have changed over the past four years

and I think they'll probably be different four years from now," Chaffin says. "You enter medical school with high ideals and that changes as you look at the mechanics of it. You don't just walk into a room and heal someone. It's more complex—on the medical side and on the personal side—than I ever imagined four years ago."

Mike Calfee is in a position that may seem like a distant dream to Taylor and Hutchins and a goal almost within reach for Beasley and Chaffin. He graduated from medical school at UT Memphis in 1995 and he now is serving the second year of a five-year orthopedics residency at The Campbell Clinic.

"This is a whole new learning experience. It's almost like starting from scratch," Calfee says. "In medical school, we didn't learn a lot about orthopedics. This is a new language."

Calfee, also from Cleveland, Tenn., entered medical school after receiving his undergraduate degree in biology and religious studies in 1991 from the University of Tennessee, Knoxville. Looking back on his medical school career, Calfee says that the second year was the most difficult.

"I really pity those students who are in their second year. For me, that was the low point," Calfee says. "I pretty much had to lock myself up in a cubbyhole and study all the time. But it got better from that point on."

It was during his third year of medical school that Calfee decided to go into orthopedics. While his plans for the future are uncertain, he says he would like to practice medicine in a small town—possibly in Middle or East Tennessee. He has an older brother, Eric, a 1993 graduate of UT Memphis who went into obstetrics/gynecology, who plans to practice in Dalton, Ga.

"I'm from Cleveland and my wife is from Nashville, so we may move somewhere between those two areas," Calfee says. "My brother is moving to Georgia and he's asked me to go into practice with him. We'll have to see how things look three years from now."

Calfee says he's spent a lot of time over the past six years thinking about the future. "A lot of students and residents are worried about where things are going in health care," Calfee says. "I don't think everything has panned out yet. You still have to worry about getting a job when you get out. You think about that even as a resident."

"I think most do end up getting jobs, although they may not always get exactly what they want," Calfee adds. "The

"My ideas and expectations of medicine have changed over the past four years and I think they'll probably be different four years from now . . . You don't just walk into a room and heal someone. It's more complex—on the medical side and on the personal side—than I ever imagined four years ago."

Curt Chaffin
Fourth-Year Medical Student

primary care doctors can pretty much say where they want to go. But it's harder if you want to practice in a big city. That's one reason I think I'll end up in small town America."

Calfee is fortunate in that he doesn't have a lot of student loans to repay. Generally, most loan agencies require former students to start making payments during their second year of residency.

According to Hershel P. Wall, MD, associate dean of admissions and dean of stu-

dents at UT Memphis, Calfee, in finding a good residency position, has overcome one of the major challenges for today's graduating medical students.

"The major challenge today for graduating seniors is to find a postgraduate program that will continue to stimulate them and satisfy their personal and professional needs," Wall says. "I think it's fair to say that the environment is very competitive. But the quality of our students and graduates remains very high."

Both Hunt and Wall say that the graduates they've worked with remain just as optimistic and enthusiastic as the first-year medical students.

"A number of people think that students are less idealistic when they graduate than when they come in. I don't think that's the case," Hunt says. "By the time the students graduate, they are more informed. They have more knowledge and more experience. They're wiser than when they entered medical school."

As head of the Underserved Areas Clinical Scholars Program, Hunt recruits students for the program and works with them through their four years of medical school. Since stepping down from his former position as chancellor in 1991, Hunt also has served on the College of Medicine's admissions committee.

Wall, a member of the UT Memphis faculty since 1965, has served as a member of the admissions committee since 1966. He was named chairman and assistant dean of admissions in 1975, and dean of students in 1982.

"I'm not sure that through the years altruism and idealism have changed that much," Wall says. "I think most young people who are coming into medicine are coming for the same reasons. They're bright and they're looking for a stimulating education and a stimulating professional career. Most of them are still interested in serving people. That doesn't change."□

Loss Prevention Case of the Month

Postoperative Delay

J. Kelley Avery, MD



Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

A 53-year old woman was discovered incidentally to have gallstones about 10 years before her referral to a general surgeon. She had equivocal episodes of upper gastrointestinal symptoms on rare occasions for the entire period. During the year before her referral the symptoms of "indigestion, bloating, heartburn, and upper abdominal pain" had become more troublesome and frequent. The pains were said to occur mostly at night, keeping her awake, and were sometimes relieved by antacids. Although the pains had become more troublesome in the past year, she had not required narcotics for relief. She gave no history of other GI symptoms, and had not had fever, weight loss, or change in bowel habits. The pain had been attributed to a known hiatal hernia with gastroesophageal reflux. Antispasmodics had been used, along with the

antacids. She had hypertension and adult onset diabetes that had been under good control by diet alone.

The physical examination revealed a moderately obese woman with no abdominal tenderness or masses. The stools were free of blood. A recent ultrasound examination revealed two 1.5-cm gallstones.

Because of the long history of abdominal symptoms, the presence of gallstones, and the failure to respond to conservative treatment, including a low-fat diet, the patient was scheduled for a laparoscopic cholecystectomy to be done as

an outpatient. In the physician's office there was a thorough discussion of the risks and benefits of the planned procedure, which included a book giving a good description of the operation and possible complications. The surgery was totally uneventful. The findings were compatible with chronic inflammation of the gallbladder, and she was able to be discharged on the day of surgery to go home.

She was seen as an outpatient in the physician's office frankly jaundiced, two days after she had become very nauseated and vomited several times. This seemed to respond to antiemetic suppositories, and at the time the patient seemed to be improving and the jaundice was thought to be clearing some. Laboratory tests on this visit revealed elevated liver enzymes and total bilirubin of 9.5 mg/dl. The WBC count was normal. One week later the patient was again seen in the office and was thought to be "about the same." She was still "very jaundiced." She was admitted to the hospital under the care of a gastroenterologist. Ultrasound examination revealed "slight dilatation of the biliary tree." The patient was examined endoscopically and the common duct was found to be "markedly narrowed," with some dilatation of the structure above the point of narrowing. "Multiple surgical clips" were present in the area of the narrowing, but the stricture was said to be "smooth" suggesting a "benign" process. A stent was placed across the stricture, with "almost complete" emptying of the contrast media from the intrahepatic duct system. Three days after the placement of the stent the patient returned to the hospital with pain, chills, fever, and subscapular pain. The patient was again examined endoscopically, at which time the stent was removed and replaced with a larger stent. A sphincterotomy was done and the stricture was dilated. The bilirubin on admission was 5.5 mg/dl, and on discharge it was 1.5 mg/dl. It is now a month since the initial surgery. Two weeks later there was a negative quantitative nuclear medicine scan.

With no evidence of bile duct obstruction and feeling well, the patient was advised that a trip out of the country with her husband was all right. Two days after her arrival, however, she was ill with fever and the stent was thought to have become obstructed. She returned to her home in the states, where studies ordered by her gastroenterologist revealed "worsening of hepatic function consistent with hepatic parenchymal

disease . . . Between the removal and replacement of stents a repeat cholangiogram was done and again showed a high grade stricture." At this time "definitive" surgery was recommended by the physician.

Because the patient had moved to another city, her care was transferred to a biliary reconstructive surgeon there. It was agreed that "she did need permanent internal drainage of the stenotic common hepatic duct." She had a hepaticojejunostomy and excision of the scarred portion of the common hepatic duct. Postoperatively, the patient did well and was tolerating a normal diet two weeks after surgery.

Loss Prevention Comments

Common duct injury is a known complication of cholecystectomy whether it is done as an open procedure or laparoscopically. This patient had unmistakable signs of common duct injury with obstruction within a few days of operation. Thorough evaluation of the complication was done by the attending surgeon and consultants, who thought that she had sustained a thermal injury to the common duct and

that the initial approach to therapy ought to be placement of a stent across the area of injury. This began about two and a half weeks after the operation, but the team seemed reluctant to move more aggressively toward permanent treatment. Most of the experts who reviewed this case believed that the delay in ordering the first ERCP was unacceptable and that repeated stenting and dilatation of the duct should have led to surgical correction much sooner.

When a video made during the operation was viewed by experts it was their opinion that it could be interpreted as showing some hesitance and awkwardness by the operating surgeon. Surgeons who make a practice of giving their patients copies of the video tape made at surgery might consider that from a medicolegal standpoint the tape, if it is used in litigation, can only be used to aid the plaintiff and not the defendant surgeon.

This case was settled primarily because no expert could be found to fully support the management of this case in which the common duct was injured as a complication of laparoscopic cholecystectomy. □

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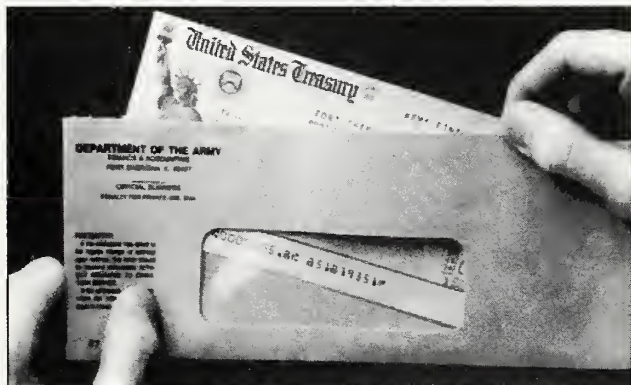
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Patient Information on the Internet

Irish Bahan

Is a little information a dangerous thing? Or will the easy access to information on the Internet be the springboard for patients to better manage their own care?

Traditionally, when patients have wanted information about their health, they've gone to their physician, a friend, a bookstore or library, or the popular press. And they've often been frustrated. Now, they can simply jump on the 'Net and find reams of information. Some of it is valid and current, and some is not.

If you have been faced with a patient, computer printout in hand, demanding to know why you have not tried the treatment it describes, you've realized a pitfall of this information available at a fingertip.

Cyberspace is glamorous right now. It is a new medium. Using the 'Net and dropping its emerging vocabulary into conversation makes us feel a part of the dizzying pace of technologic advancement. The wealth of information is ripe for picking. For everyone, from international corporations, to small business, to individuals, the rush to publish on the Internet is on. Freedom of speech is our right. It's easy to set up a home page: how-to books and eager service organizations abound. In the medical arena, it's a logical extension of a marketing campaign, less expensive than printing a newsletter, and certainly easier than having an article accepted in a journal or magazine. New sites are added every day.

But with all this momentum, it's important to step back and realize that not everyone's on it—yet. Not every household has yet spent the thousand dollars it takes to buy a computer capable of hooking onto the 'Net. Most home computers bought six or eight years ago are not capable of using the World Wide Web, with its more advanced graphics that make possible WYSIWYG "What You See Is What You Get." And surfing the 'Net is time-consuming. People can be over-

whelmed by the sheer wealth of choices or bored by a painstaking search for the exact information they want. And, generally speaking, twentysomethings and thirtysomethings are more likely to use it than older patients.

Still, people who are navigating the present and emerging health care environment need to be more informed than ever before. They want to be well, and, in the final analysis, understanding promotes compliance. Because of its accessibility, more and more of them will turn to cyberspace, often without the knowledge to judge the validity of what they find. They will challenge the authority of their physician, demand explanations, and in some cases prod physicians to keep up to date. Even though the overall effects are positive, the explosion of information will continue to pressure physicians.

Clark E. Julius, MD, of the Knoxville Dermatology Group, finds that patients frequently come to him with factual information about health care, such as on pharmaceuticals. When the information from the 'Net is disguised as editorial text but actually presented for marketing purposes, the lack of balance can be difficult for a lay person to discern. He finds that often he must take the time to fill in what was omitted, such as the possibility of success, the cost, or whether their insurance will cover the cost in certain situations.

A logical answer to the dilemma of information/disinformation/semi-information is the creation of sites that serve patients well. At the Eskin Biomedical Library of Vanderbilt, Assistant Professor of Biomedical Informatics Nunzia Giuse explains, "When we decided to create a Web site, we spent a good deal of time defining our goals. We realized it would take a major commitment. We have had to find the best resources for material, organize it, edit it, create pleasing graphics and then keep it current, even as we expand our offerings."

On a smaller scale, Julius is one of a growing number of physicians practicing across the state who has established his own home page. "It was easy," he says. "I sent the information to a company who did it all, and it costs about \$30 a month to keep up." He plans to do monthly updates and keep the presentation simple and user friendly. "I know the questions that patients ask over and over," he emphasizes. "And some of the questions are seasonal. Next spring I'll cover sunburn prevention, as an example. Other material might be background education so that patients can make better decisions when I offer choices about treatments."

Irish Bahan is a communications consultant who specializes in writing and marketing for health care.

Another way physician practices use the Internet to provide education is to set up a computer connected to the 'Net that offers a structured menu allowing patients to visit pre-selected sites and print out material. Another method of controlled access is to create an Intranet. Physicians choose material from the Internet, download it to their own computer, perhaps edit it or incorporate their own material, and then print it out on demand for their patients. An Intranet can serve more than one location. In another user-specific application, Merck & Co., Inc. has designed a worldwide Intranet to give their 42,500 employees access to research materials, as well as company-related information.

Tomorrow will bring even more possibilities. Meanwhile, your patients, who are being given the message that they should become better consumers of health care, will continue to be exposed to a wider range of information in print and broadcast, as well as on the 'Net. A first step is to offer patients the criteria for judging its validity. The following "Commonsense Guidelines for Surfing the 'Net" might seem self-evident to a medical professional experienced in filtering through masses of conflicting scientific data. To patients, however, it could be helpful.

- If information prominently features a product by brand name, be aware that it might simply be advertising in disguise. The information can be correct but not necessarily balanced.

- Best sources are major universities, voluntary health organizations with familiar names, such as the American Medical Association, American Heart Association, or the Lung Association.

- Avoid chat rooms.

- Forums can feature both professionals and non-professionals. Feel free to ask for credentials. Again, major universities are a good indication.

- If the information is based on research, again, look for the names of major universities or hospitals. Also look for results based on large numbers of subjects—hundreds or thousands—or results gathered over a long period of time.

- Medline, a service of the National Library of Medicine.

- The Merck Manual.

- Look for organizations underwritten by the federal government such as the National Institutes of Health (NIH), U.S. Department of Health and Human Services, FDA, or the Centers for Disease Control/Prevention (CDC). □

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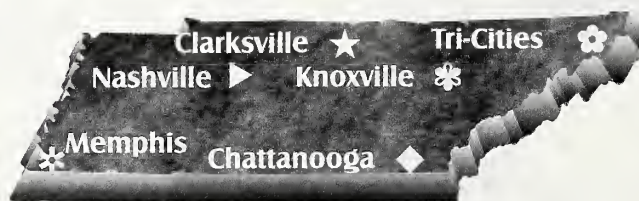
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Original Contribution

Nutritional Status and Mortality in Respiratory Failure Caused by Tuberculosis

Jay B. Mehta, MD; Cheryl L. Fields, MD;
Ryland P. Byrd Jr., MD; Thomas M. Roy, MD

Introduction

Historically, the association of respiratory failure and active tuberculosis (TB) has a greater than 80% mortality. The classic reference to TB as "consumption" relays the proper impression that the untreated patient with active TB frequently becomes malnourished. Although there is firm evidence that nutritional status influences the outcome of patients with chronic obstructive lung problems,¹ its influence in the respiratory failure due to TB is less well documented. Investigators frequently attribute poor survival to disease processes coexisting with TB or a delay in the initiation of proper antitubercular therapy,² but definite predictors of survival for patients with pulmonary TB and respiratory failure have not yet emerged.³

The prognostic scoring system most frequently applied to patients admitted to the medical intensive care unit (ICU) is the revised Acute Physiology and Chronic Health Evaluation (APACHE II). This scoring system is based on 12 objective parameters and is a useful tool for predicting survival in a number of critical illnesses.^{4,5} It has not, however, been validated in respiratory failure due to TB. The usefulness of

ABSTRACT

A retrospective analysis of the records of all patients admitted to the intensive care unit with respiratory failure and nonmiliary tuberculosis was conducted to determine variables that might be predictive of survival. Nutritional status, as reflected by the patient's serum albumin and hemoglobin, were the best predictors of survival and were more helpful than the widely accepted APACHE II scoring system. This observation suggests that early and aggressive attention to improving the patient's nutritional status may be as important as effective antitubercular therapy and mechanical ventilation in salvaging these individuals.

APACHE II has not been compared in this subgroup of patients to the nutritional status of the patient as reflected by the serum albumin and the hemoglobin.

Methods

We identified all patients treated for TB who required admission to the ICU between Jan. 1, 1986 and Jan. 1, 1994 during which period we also

managed the unit. To insure that no patients were overlooked, continued crosschecks were made against the infection control census and computer-generated diagnosis-related grouping. Only those patients were included in this study who had respiratory failure that required mechanical ventilation and whose cultures confirmed pulmonary TB.

The APACHE II score was calculated for each patient on day 1 of admission to the ICU. Each patient's serum albumin and serum hemoglobin at the time of admission into the unit were recorded. These variables were contrasted to the patient's duration of stay in the ICU, the nature of the chest radiographs of each patient, the alveolar-arterial oxygen ratio, and the patient's outcome.

Numerical variables were analyzed for statistical significance using the two sample independent-groups t-test. A *P* value of less than 0.05 was accepted as statistically significant.

Results

During the eight-year study period, 15 patients were admitted to the ICU with concurrent respiratory failure and culture-positive pulmonary TB. All patients were diagnosed with pulmonary TB after developing respiratory failure. Each patient was thought to be in respiratory failure primarily, if

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TABLE 1
CLINICAL DATA OF STUDY GROUP

Patient	Age	Sex	Risk Factor	Chest X-ray	Outcome
1	48	M	None	Cavitary	Died
2	58	M	Alcohol	Noncavitary	Died
3	41	M	Alcohol	Noncavitary	Died
4	52	M	Alcohol	Cavitary	Died
5	45	M	Alcohol	Noncavitary	Died
6	63	M	Alcohol	Noncavitary	Died
7	72	M	Alcohol	Cavitary	Died
8	55	M	Cancer	Cavitary	Died
9	40	M	Diabetes	Cavitary	Died
10	50	M	Alcohol	Cavitary	Survived
11	53	M	COPD	Noncavitary	Survived
12	68	M	None	Cavitary	Survived
13	53	M	Alcohol	Noncavitary	Survived
14	66	M	None	Noncavitary	Survived
15	40	M	HIV	Noncavitary	Survived

not solely, due to his pulmonary infection. All patients were male, with a mean age of 53.6 ± 10.2 years (range 40-70) (Table 1).

Recognized risk factors for TB included alcoholism (n=9), malignancy (n=1), COPD requiring steroids (n=1), and diabetes mellitus (n=1). One patient was HIV positive, with TB as his AIDS-defining illness.

Each patient required intubation and ventilatory support with mechanical ventilation. Mechanical ventilation was conducted in the standard fashion using the assist-control mode and a volume cycled ventilator. The mean duration of mechanical ventilation was 19.5 ± 25.0 days (range 1 to 72). No patient sustained pulmonary barotrauma or complication of ventilation that might have influenced outcome.

Seven patients had radiographs that demonstrated unilateral or bilateral apical cavitary lesions typically associated with reactivation TB. Eight patients had radiographic evidence of unilobar or multilobar noncavitary infiltrates. Two patients also had radiographically apparent pleural effusions.

Although each patient had the diagnosis of TB confirmed by growth of *Mycobacterium tuberculosis* on culture of respiratory secretions, antitubercular therapy was started when acid-fast organisms were identified on smear or when the attending physician believed that TB was a probable diagnosis. Respiratory secretions were obtained through the endotracheal tube in 13 patients and by bronchoscopy in two. The mean interim between the time of admission to the ICU and initiation of therapy was 5.9 ± 12.0 days (range 1 to 48).

Antitubercular therapy was uniform for each patient, employing a four-drug regimen of isoniazid, rifampin, ethambutol, and pyrazinamide. No individual had a drug-resistant strain of TB.

By chart review, it was determined that only four of the 15 patients tolerated the daily amount of enteral feedings suf-

ficient to achieve the supplementation recommended by the dietary assessment. All other patients tolerated enteral feeding in varying amounts with frequently interrupted dietary therapy. No patient received total parenteral nutrition by central line. Three of the patients who received steady dietary supplement survived.

Six patients survived to be extubated and discharged from the hospital. Nine patients died in the ICU. Postmortem examination was not permitted on any of the nonsurvivors.

Clinical and laboratory parameters of the survivors and nonsurvivors are displayed in Table 2. Only the serum albumin and hemoglobin values differed statistically between these two groups.

Discussion

Patients with TB who require admission to the ICU because of acute respiratory failure have a high mortality. Approximately 25% will survive.⁶⁻⁸ Prognostic factors that identify the patient most likely to survive have not been uniformly adopted. In our study group, application of the APACHE II scoring system did not successfully delineate survivors from nonsurvivors. Although the mean value of the nonsurvivors was slightly higher than the survivors, the predictive utility of the APACHE II system appears limited in this patient population.⁹

In this subgroup of patients with TB who developed respiratory failure, the serum albumin and hemoglobin appeared to be the best indices of survival. Not surprisingly, nutritional status had been previously reported as an important outcome variable for the TB population in general.¹⁰ Hypoalbuminemia remains an uncommon feature of patients with active TB, and its occurrence has been suggested as being a marker of a terminal illness.¹¹ Anemia has been previously reported among tuberculous nonsurvivors with respiratory insufficiency.¹²

The survival of patients with respiratory insufficiency and active pulmonary TB continues to be poor. Our mortality of 60% is consistent with that of other studies, despite the ad-

TABLE 2
COMPARISON OF CLINICAL AND LABORATORY DATA OF SURVIVORS VS. NONSURVIVORS

Variable	Nonsurvivors (9)	Survivors (5)	P Value
Age in years	52.7 ± 10.5	55.0 ± 10.5	0.68
WBC count	11.7 ± 8.4	10.5 ± 2.8	0.69
Hemoglobin	9.6 ± 1.6	12.6 ± 2.0	0.01*
PaO ₂ /PAO ₂ ratio	0.36 ± 0.24	0.28 ± 0.13	0.51
Creatinine	0.78 ± 0.43	0.75 ± 0.38	0.90
ICU stay in days	12.3 ± 22.7	33.8 ± 27.9	0.12
APACHE score	22.9 ± 6.4	17.0 ± 6.5	0.11
Albumin	2.08 ± 0.5	2.97 ± 0.9	0.02*

* Statistically significant.

ministration of four-drug antitubercular therapy.¹³ Since this limited study suggests that nutrition, as reflected by serum albumin and hemoglobin, may have an impact on survival, we would encourage closer attention to modifying these parameters through dietary support. Now that antitubercular therapy is effective and present technology allows safe maintenance of mechanical ventilation, the final factor in insuring survival of patients with TB and respiratory failure may rest on nutritional repletion.

We hope that this pilot report will encourage investigators to develop strategies that provide early and adequate dietary intervention as an adjunctive therapeutic maneuver. It is not yet known what degree of nutritional modification will significantly affect the survival of patients with TB and respiratory failure, but our observations encourage further investigation in this area. □

References

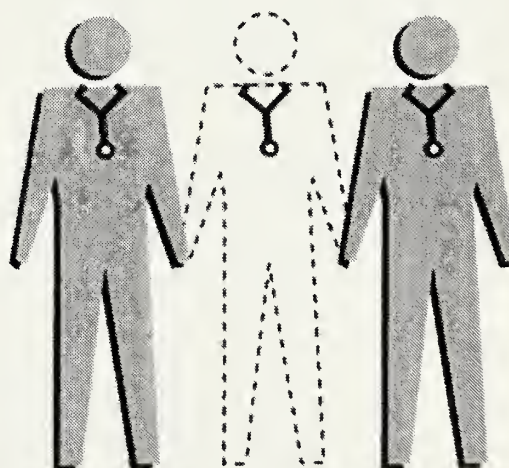
1. Gray-Donald K, Gihons L, Shapiro SH, et al: Nutritional status and mortality in chronic obstructive pulmonary disease. *Am J Respir Crit Care Med* 153:961-964, 1996.
2. Frame RN, Johnson MC, Eichenhorn MS, et al: Active tuberculosis in the medical intensive care unit: a 15-year retrospective analysis. *Crit Care Med* 15:1012-1014, 1987.
3. Barnes PF, Leedom JM, Chan LS, et al: Predictors of short-term prognosis in patients with pulmonary tuberculosis. *J Infect Dis* 158:366-371, 1988.
4. Knaus WA, Draper EA, Wagner DP, et al: APACHE II: A severity of disease classification system. *Crit Care Med* 13:818-829, 1985.
5. Wong DT, Crofts SL, Gomez M, et al: Evaluation of predictive ability of APACHE II system and hospital outcome in Canadian intensive care unit patients. *Crit Care Med* 23:1177-1183, 1995.
6. Levy H, Kallenbach JM, Feldman C, et al: Acute respiratory failure in active tuberculosis. *Crit Care Med* 15:221-225, 1987.
7. Helfner JE, Strange C, Sahn SA: The impact of respiratory failure on the diagnosis of tuberculosis. *Arch Intern Med* 148:1103-1108, 1988.
8. Goldstein MS, MacIntyre DS, Collier C: The spectrum of active tuberculosis and respiratory failure in a medical intensive care unit. *Am Rev Respir Dis* 115:A339, 1977.
9. Chang RW, Jacobs S, Lee B, et al: Predicting deaths among intensive care unit patients. *Crit Care Med* 16:34-42, 1988.
10. Davis CE Jr, Carpenter JL, McAllister CK, et al: Tuberculosis. Cause of death in the anti-tuberc era. *Chest* 88:726-729, 1985.
11. Page MI, Lunn JS: Experience with tuberculosis in a public teaching hospital. *Am J Med* 77:667-670, 1984.
12. Agarwal MK, Muthuswamy PP, Banner AS, et al: Respiratory failure in pulmonary tuberculosis. *Chest* 72:605-609, 1977.
13. Penner C, Roberts D, Kunimoto D, et al: Tuberculosis as a primary cause of respiratory failure requiring mechanical ventilation. *Am J Respir Crit Care Med* 151:867-872, 1995.

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Trauma Rounds

Traumatic Pseudocyst of the Spleen

Jonathan D. Woody, MD; Phillip R. Craft, MD;
Thaddeus S. Fabian, MD; Lewis B. Somberg, MD

Case Report

A 22-year-old man sustained blunt abdominal trauma in addition to multiple orthopedic injuries from a motor vehicle crash. CT scan of his abdomen showed a grade I liver laceration and a grade III splenic injury. Because of suspected continuing blood loss and early peritonitis he was taken to the operating room for exploratory laparotomy, where suture repair of the liver laceration and splenorrhaphy with a Vicryl mesh wrap were performed.

The patient's hospital course was complicated by acute respiratory distress syndrome (ARDS) requiring prolonged mechanical ventilation during a three-week ICU stay. By the 25th hospital day, he had developed left upper quadrant abdominal pain and abdominal distention. Abdominal CT scan demonstrated a 25-cm perisplenic fluid collection (Fig. 1). He was hemodynamically stable and there was no drop in his hematocrit. CT-guided percutaneous drainage of the collection yielded 2,500 cc of serosanguinous fluid. Analysis of the fluid revealed an amylase of 5 U/L and bilirubin was undetectable. Gram stain and culture of the fluid were negative. The drain was removed in four days and the patient was discharged home.

Seven days after discharge, the patient returned to the emergency department complaining of abdominal pain, abdominal distention, and decreased appetite. Abdominal CT scan demonstrated a 17-cm reaccumulation of perisplenic fluid, repeat CT-guided percutaneous drainage of which yielded 2,000 cc of serosanguinous fluid. He was discharged home with the drain in place.

Nine days later he returned with fever and purulent discharge from the drain, culture of which grew methicillin-resistant *Staphylococcus aureus* (MSRA) and *Corynebacterium* species. Treatment with vancomycin and ofloxacin was begun, with further evaluation to determine any pancreatic or biliary involvement. ERCP demonstrated an intact pancreatic duct, but the common bile duct could not be

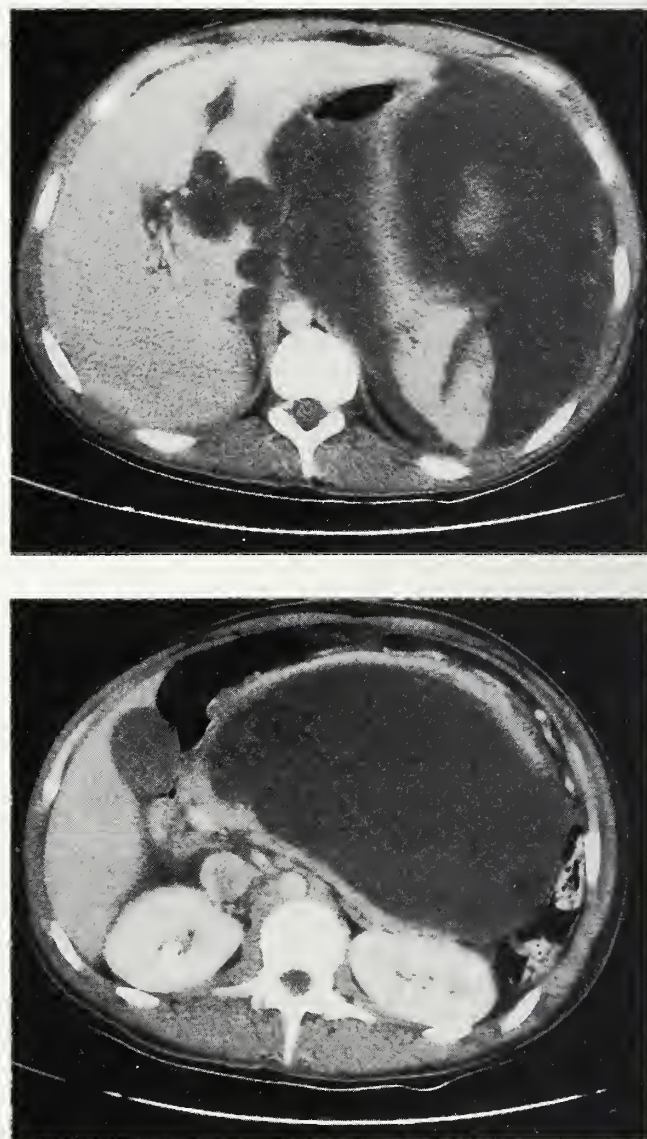


Figure 1. (Top) Double contrast enhanced CT scan of the upper abdomen in the region of the spleen demonstrating a large splenic pseudocyst. (Bottom) Image from the same CT scan demonstrating compression of the left kidney and displacement of abdominal contents.

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cannulated. There was normal visualization of the gallbladder on nuclear medicine scan, and the common bile duct was patent without evidence of biliary leak. Exploratory laparotomy revealed a large amount of purulent fluid and a hematoma within a dense, fibrous capsule originating from the superior pole of the spleen. A portion of the Vicryl mesh wrap was still intact. Splenectomy with complete excision of the pseudocyst was performed, and a drain was placed in the splenic bed; it was removed on the fourth postoperative day. The patient recovered uneventfully, was discharged home, and has done well on follow-up.

Discussion

Though splenic pseudocysts are rare, in the United States they are five times as common as parasitic splenic cysts.¹ In 1958, Martin introduced a classification of splenic cysts (Table 1).²

Splenic pseudocysts generally result from injury to the spleen, although 30% of patients deny a history of trauma.³ Pseudocyst formation is believed to be the result of degradation of a perisplenic hematoma. The resorbing hematoma and fluid produced in response to the inflammation are surrounded by a dense fibrous wall.⁴ Splenic pseudocysts are unilocular in 80% of cases and in 50% of cases contain calcium deposits in the capsule.¹ These are not true cysts, since they are devoid of an epithelial lining.

Patients with a splenic pseudocyst present a variety of symptoms. Up to one-third of patients are asymptomatic.⁴ The most frequent complaint is of vague abdominal pain or left upper quadrant pain radiating to the shoulder.¹ Other symptoms include postprandial pain, nausea, vomiting, anorexia, dysphagia, a sense of fullness, flatulence, diarrhea, constipation, dyspnea, tachycardia, and left renal colic. A palpable left upper quadrant mass is found in 40% of patients.³

The diagnostic workup of splenic pseudocyst has evolved over the years. Historically, it has included endoscopy, upper GI series, barium enema, intravenous pyelography, arteriography, splenoportography, and splenocystography. These are unnecessary today. Workup should begin with plain abdominal radiographs, which will detect a mass in 50% of

TABLE 1

MARTIN'S CLASSIFICATION OF SPLENIC CYSTS

- I. Primary or true (with an epithelial lining)
 - A. Parasitic - hydatid
 - B. Non-parasitic
 1. Congenital
 2. Neoplastic
 - a. dermoid
 - b. epidermoid
 - c. lymphangioma
- II. Secondary or false (without an epithelial lining)

cases.³ Ultrasound can distinguish between solid and cystic masses. The diagnostic test of choice, though, is the CT scan, as it provides the most information, clearly delineating the extent of the pseudocyst and demonstrating any other intra-abdominal pathology.

Once diagnosed, splenic pseudocysts should be treated if they are symptomatic or larger than 10 cm.¹ Risks of the untreated splenic pseudocyst include an increase in symptoms, spontaneous rupture, or infection. Traditionally, splenectomy was the treatment of choice. Currently, many authors advocate splenic preservation to avoid the possibility of overwhelming post-splenectomy sepsis. Spleen sparing procedures include partial splenic decapsulation, cyst marsupialization, or splenorrhaphy with cyst marsupialization and omental packing of the remaining cavity.^{3,4} Despite a high recurrence rate, radiographically assisted percutaneous drainage is an option.¹

Traumatic pseudocyst of the spleen is uncommon. Still, it must be considered a potential complication in patients with a history of splenic injury. Diagnosis and treatment are relatively straightforward, and patients usually do very well. □

References

1. Smith GW: Tumors, cysts, and abscesses of the spleen, in Cameron JL (ed): *Current Surgical Therapy*, ed 5. St. Louis, Mosby Yearhook, Inc, 1995, pp 474-478.
2. Park JY, Song KT: Splenic cyst: a case report and review of the literature. *Am Surg* 37:544-547, 1971.
3. Edmond RE, Rochon BR, McPhail JF: Case report: a traumatic splenic pseudocyst. *J Trauma* 30:349-352, 1990.
4. Brown JJ, Bynoe RP, Greene FL, et al: Splenic salvage techniques in the management of pseudocysts of the spleen. *South Med J* 79:710-711, 1986.

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Stroke Prevention Series

Medical Revolution: The Prevention and Treatment of Stroke, 1996

Part 1. Stroke Prevention and Carotid Endarterectomy

Howard S. Kirshner, MD

Introduction

This article marks the first in a series on the revolutionary changes that have occurred in the prevention and treatment of stroke. Of the nearly 500,000 stroke victims each year in the United States, 140,000 fatalities make stroke the third leading cause of death; more importantly, the survivors make stroke the leading cause of neurologic disability in adults. Stroke frequency and mortality are high in the Southeast, sometimes called the "Stroke Belt." Far from being an inevitable complication of aging and vascular disease, stroke has recently become the subject of aggressive treatments. First, large clinical trials have established the efficacy of preventive treatments, the first revolution in the medical management of stroke^{1,2} (Table 1). The later 1990s promise a second revolution in the treatment of stroke, based on new scientific advances concerning the mechanisms of ischemia and cell death.³ These treatments include thrombolytic agents to dissolve clots, and "neuroprotective" drugs, which prevent ischemic cell death. Stroke deficits can then be modified even after they have begun, making stroke an area of active therapeutics.

This first article will review stroke prevention in the population, and carotid endarterectomy. The second article will cover antiplatelet therapy for thrombotic disorders, anticoagulation for sources of embolism to the brain, and a brief introduction to acute stroke therapy, including the recently approved tissue-type thromboplastin activator (tPA). Later articles will discuss a range of topics related to stroke prevention and treatment.

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TABLE 1
TREATMENTS EFFECTIVE IN PREVENTING STROKE

Groups of Patients	Preventive Treatment
Normal persons	Low cholesterol diet, exercise
Normal persons	Avoid smoking
Hypertensives	Control blood pressure
Diabetics	Control glucose
Atrial fibrillation, other heart disorders	Warfarin anticoagulation
TIA, minor stroke, carotid stenosis	Carotid endarterectomy
TIA, minor stroke, no carotid stenosis	Aspirin or ticlopidine
Major stroke, secondary prevention	Ticlopidine

Most important in stroke prevention is the management risk factors in the population, including promotion of healthy diets, adequate exercise, cessation of smoking, and screening for hypertension. The public must be educated about risk factors and warning signs of stroke. Most strokes are preventable, if appropriate measures are undertaken early. The most common mechanisms of stroke are thrombosis in large and small vessel territories, and infarcts secondary to cerebral emboli. Cerebral hemorrhage will be considered in future articles.

Surgical Prevention of Stroke

Carotid endarterectomy has been in clinical use since 1956, but early studies failed to confirm benefit.⁴ In 1991, three large studies all found a reduction of ipsilateral stroke in operated patients with "symptomatic stenosis," transient ischemic attack (TIA), or minor nondisabling stroke (Table 2). The NASCET (North American Symptomatic Carotid Endarterectomy Trial)⁵ study included 595 patients with TIA or minor stroke and carotid stenosis of 70% to 99%. Surgical patients had fewer strokes (9%) than the aspirin-treated medical group (26%), amounting to prevention of 9.5 strokes per 100 patients operated upon per year. The degree of benefit was proportional to the degree of stenosis, over 20% at 90%

TABLE 2

CAROTID ENDARTERECTOMY FOR SYMPTOMATIC PATIENTS

Measure	NASCET Trial	European Trial	VA Trial
Number of patients	595	778	189
Criterion - % stenosis	>70%	>70%	>50%*
Length of trial	2 yrs	3 yrs	2 yrs
Stroke: surgical Rx	9%	10.3%	7.9%
Stroke: medical Rx	26%	16.8%	25.6%
Morbidity/mortality	5%	7.5%	5.5%

* For those patients with 50% to 70% stenosis, there was no difference in stroke risk between surgical and medical therapy.

stenosis. The European Carotid Surgery Trial,⁶ with similar criteria of TIA or mild stroke and >70% ipsilateral stenosis, showed similar benefit. In the VA "symptomatic" study,⁷ surgical patients with >50% stenosis had a lower incidence of crescendo TIA or stroke than medical patients (7.9% vs 25.6%), but no benefit was seen in patients with 50% to 70% stenosis. Seventy percent stenosis of an internal carotid artery in either angiographic projection has become the consensus criterion for surgery in symptomatic carotid stenosis. Morbidity and mortality in the three trials approached 5%, a very acceptable figure considering the high risk of stroke in these patients.

Carotid endarterectomy remains controversial in asymptomatic patients. The VA study of 444 men with asymptomatic stenosis⁸ reported an 8% incidence of ipsilateral TIA or stroke in the surgical group versus 20.6% in the medical group. Although this result is favorable, the more important endpoint is stroke rather than TIA. Unheralded stroke occurred in 4.7% of surgical patients and 9.4% of medical patients, but a 4.7% complication rate of arteriography and surgery made the overall mortality/morbidity identical in the two groups. A second study on asymptomatic carotid stenosis (ACAS)⁹ was termi-

nated early because of a clear stroke reduction in surgically treated patients with >60% stenosis. Projected five-year rates for ipsilateral stroke or any perioperative major stroke or death were 5.1% in the surgical group and 11.1% in the medical group, a relative stroke reduction of 53%, or an absolute stroke reduction of 6% over five years, or 1.2% per year. This risk is lower than that of symptomatic patients, and stroke prevention in asymptomatic patients therefore requires a much lower risk of surgery. The authors recommended surgical management only with surgical risk <3%. Limitations of the study include the use of projected rather than actual data, the much lesser benefit seen in women than in men, and the lack of any correlation between degree of stenosis and degree of stroke reduction with surgery. Clinicians have been cautious in applying the study recommendations. The European Carotid Surgery Trialists Collaborative Group¹⁰ followed 2,252 patients with widely varying degrees of stenosis. Stroke risk was 2.1% with <70% stenosis and 5.7% with >70% stenosis, but no clear surgical benefit was found. At present, surgery for asymptomatic stenosis appears unjustified unless the degree of stenosis is >60% to 70% and the surgical risk is low. □

References

1. Bronner LL, Kanter DS, Manson JE: Primary prevention of stroke. *N Engl J Med* 333:1392-1400, 1995.
2. Silver B, Weber J, Fisher M: Medical therapy for ischemic stroke. *Clin Neuropharm* 19:101-128, 1996.
3. Pulsinelli W: Pathophysiology of acute ischaemic stroke. *Lancet* 339:533-536, 1992.
4. Fields WS, Masleukov V, Meyer JS, et al: Joint study of extracranial arterial occlusion. *JAMA* 211:1993-2003, 1970.
5. North American Symptomatic Carotid Endarterectomy Trial Collaborators: Beneficial effect of carotid endarterectomy in symptomatic patients with high-grade carotid stenosis. *N Engl J Med* 325:445-453, 1991.
6. European Carotid Surgery Trialists' Collaborative Group: MRC European carotid surgery trial: interim results for symptomatic patients with severe (70% to 99%) or with mild (0 to 29%) carotid stenosis. *Lancet* 337:1235-1243, 1991.
7. Mayberg MR, Wilson SE, Yatsu F, et al: Carotid endarterectomy and prevention of cerebral ischemia in symptomatic carotid stenosis. *JAMA* 266:3289-3294, 1991.
8. Hohson RW, Weiss DG, Fields WS, et al: Efficacy of carotid endarterectomy for asymptomatic carotid stenosis. *N Engl J Med* 328:221-227, 1993.
9. ACAS: Endarterectomy for asymptomatic carotid artery stenosis. *JAMA* 273:1421-1428, 1995.
10. European Carotid Surgery Trialists Collaborative Group: Risk of stroke in the distribution of an asymptomatic carotid artery. *Lancet* 345:209-212, 1995.

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Vanderbilt Morning Report

Shortness of Breath and Chest Pain In a Patient With Scleroderma

Case Report

A 61-year-old woman with a 22-year history of scleroderma and hypertension presented herself to the Vanderbilt Internal Medicine Clinic with a chief complaint of intermittent shortness of breath. She described several episodes of "smothering," and a feeling of "the room closing in on me." She also described "a hurting in the chest" as a tight sensation when the shortness of breath subsided. The episodes lasted 20 to 30 minutes. She denied radiation of chest pain or diaphoresis. She did note nausea on one occasion, and rarely had a cough associated with the shortness of breath. These episodes always occurred at night, but did not awaken her from sleep. She had no episodes associated with activity, nor did they occur in the daytime. She denied gastroesophageal reflux symptoms, dysphagia, or odynophagia, and stated that she had been eating her "usual diet." She had not tried any medications in an attempt to relieve these symptoms.

Her medications include Captopril 75 mg three times daily, hydrochlorothiazide 25 mg daily, and Keflex 500 mg tablets taken as needed for skin infections. Physical examination revealed a blood pressure of 150/100 mm Hg in the right arm and 160/90 mm Hg in the left. The pulse was 60/min and respiratory rate 16/min. Cardiovascular examination demonstrated a regular rate and rhythm without murmurs, rubs, or gallops. There was no jugular venous distention, and no chest wall tenderness to palpation. The chest was clear to auscultation and percussion except for a few coarse rhonchi at the left base, and the abdominal examination was within normal limits. There was no peripheral edema. The skin showed classic changes of scleroderma, with smooth, drawn skin on the face, neck, arms, and legs, and flexion contracture of all digits.

An EKG revealed normal sinus rhythm at 68/min with normal axis and normal PR, QRS and QT intervals. There was T wave inversion in leads V₁ through V₃ and early R wave progression, but these were unchanged from an EKG done ten years earlier. Review of past medical records revealed an upper GI series done 12 years prior with some gastroesophageal regurgitation and slow propulsion of contrast through the esophagus, but no esophageal dilation.

The patient was instructed to return to the emergency depart-

ment if her symptoms recurred, and she was scheduled for an outpatient barium swallow, which revealed considerable dilation of the esophagus with marked gastroesophageal reflux. Severe dysmotility was also noted in the esophagus, with only rare, feeble contractions in the distal portion. A chest radiograph showed interstitial fibrotic changes at the bases bilaterally, consistent with scleroderma. The patient was treated with Axid 150 mg twice daily, along with elevation of the head of the bed, and instructions to not eat within three hours of her bedtime. She reported marked improvement in her symptoms.

Discussion

Systemic sclerosis is a multisystem disease characterized by fibrosis of the skin and internal organs.¹ The exact pathophysiology is unknown, but the disease process occurs as a consequence of interactions between the vasculature, the immune system, and the mesenchymal cells (fibroblasts). This results in increased synthesis and deposition of collagen in the skin and internal organs, as well as mononuclear cell infiltration of the vasculature. There are two subsets of systemic sclerosis: diffuse and limited cutaneous scleroderma. The limited variety is defined by symmetric skin thickening limited to the fingers, extremities distally, and face, and often has the features of CREST syndrome, namely calcinosis, Raynaud's phenomenon, esophageal dysmotility, sclerodactyly, and telangiectases. Diffuse cutaneous scleroderma includes the same skin findings, but they develop more rapidly and are more extensive. There is also an increased incidence of visceral involvement. Renal disease with hypertensive crisis used to be the major cause of death in diffuse cutaneous scleroderma, but recent advances in managing this complication, especially the use of angiotensin-converting-enzyme inhibitors, has made this complication less ominous.² Pulmonary disease usually takes one of two forms: severe interstitial fibrosis, or severe pulmonary arterial hypertension. These patients have severe, progressive shortness of breath and nonproductive cough. Lung disease is now the major cause of death in scleroderma patients, as no treatment (save supportive measures) has proved effective.³ Cardiac disease is usually subclinical, and may include pericarditis, myocardial disease, and disturbances of conduction or cardiac rhythm.

The GI tract is the most common visceral organ system

Presented by Jeannine Z. P. Engel, MD, primary care chief medical resident, Vanderbilt University Medical Center, Nashville.

affected in scleroderma. Both the limited and diffuse forms can have esophageal involvement, while more extensive GI disease is found only in diffuse cutaneous disease. The esophagus is the most commonly affected area, and also the most important clinically. Early in the disease, neural dysfunction leads to incoordination between peristalsis in the lower two-thirds of the esophagus and relaxation of the lower esophageal sphincter (LES). Late in the disease there is complete loss of peristaltic activity in the lower esophagus, and LES pressure is virtually absent.⁴ This is particularly problematic because there is free reflux of stomach contents, and no barrier to aspiration. Additionally, the lack of esophageal peristalsis delays the clearance of acid reflux. Paradoxically, the decreased motility and peristalsis in the stomach and small intestine that occurs in scleroderma may limit the amount of reflux. Other common GI complications include pseudo-obstruction of the small bowel, megacolon, colonic diverticula, and diarrhea from bacterial overgrowth.

The treatment of esophageal disease and gastroesophageal reflux in patients with scleroderma is similar to that in the general population. Nonpharmacologic measures include weight loss, smoking cessation, elevation of the head of the bed, multiple small meals, and avoidance of recumbency

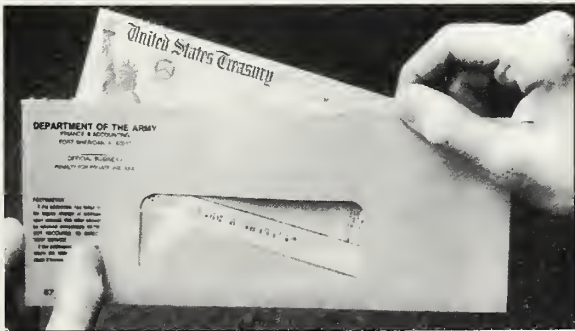
within three hours of eating. Antisecretory medications such as H₂ blockers and proton-pump inhibitors have both been effective in the treatment of GERD in scleroderma patients.^{2,4} Twice daily dosing of omeprazole is usually required. Prokinetic agents such as cisapride have been less effective. While they do increase LES pressure and facilitate gastric emptying in scleroderma patients, they have little effect on esophageal motility.² Finally, anti-reflux surgery can be considered if all other measures fail, with the realization that recurrent reflux symptoms are common, likely due to delayed gastric emptying. At the other end of the spectrum, obstructive symptoms due to the impaired esophageal motor function may occur if the anti-reflux procedure renders it "too tight." Currently, all therapeutic approaches are targeted at the GI complications of systemic sclerosis, not at the underlying cause. Until the specific pathophysiology of scleroderma is elucidated, symptomatic therapy is the only option. □

References

1. Gilliland BC: Systemic sclerosis, in *Harrison's Principles of Internal Medicine*, ed 12. New York, McGraw-Hill, 1991.
2. Legerton CW, Smith EA, Silver RM: Systemic sclerosis (scleroderma). Clinical management of its major complications. *Rheum Dis Clin N Am* 21:203-216, 1995.
3. Black CM: Scleroderma—clinical aspects. *J Intern Med* 234:115-118, 1993.
4. Sjogren RW: Gastrointestinal motility disorders in scleroderma. *Arthritis Rheum* 37:1265-1282, 1994.

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Department of Health Report

Preventing Traumatic Brain Injury

Jean Doster, MS

Introduction

In recent years, preventive medicine has become accepted and indeed essential in our efforts to forestall or avoid the negative health effects of obesity, hypertension, smoking, and other lifestyle-related illnesses. Physicians routinely counsel patients on preventive measures related to a healthy heart, advise on sodium intake as related to high blood pressure, extol the benefits of smoking cessation, and prescribe other appropriate changes that can influence overall health. Physicians also have the opportunity to provide primary prevention related to injuries, particularly traumatic brain injury (TBI). This is especially critical, given that unlike disease conditions such as high blood pressure, injuries provide no frightening "warning symptoms" that increase motivation to take preventive measures.

To create further awareness of the lifelong consequences of TBI, the National Brain Injury Association has proclaimed October as Brain Injury Awareness Month. This article provides background information on TBI, and includes prevention suggestions for physicians to use with patients of all ages.

The Problem

Each year, 2 million Americans sustain TBI from motor vehicle crashes, falls, recreation injuries, assaults, and violence. These injuries are the leading cause of death and disability of children and young adults in the United States. Of those who suffer TBI, 75,000 to 100,000 die, and 70,000 to 90,000 must live the remainder of their lives with a severe disability.¹ In Tennessee, an estimated 6,000 people with TBI are discharged from hospitals each year. The highest rate of injury is suffered by boys and young men.

The vast majority of people hospitalized for TBI are diagnosed as having mild TBI. In children, brain injuries constitute the most important subtype of pediatric injury for three main reasons: their high absolute incidence and prevalence, their disproportionately large contribution to mortality, and their ability to irrevocably alter the individual's quality of life even when not "disabling." Mild brain injury is associated with debilitating, persistent symptoms, including per-

sonality changes, headaches, a propensity to seizures, and behavior problems. Significantly more children who have suffered head injuries exhibit behavior problems in school than those who have not. Due to the absence of obvious or enduring symptoms (such as skull fracture, loss of consciousness, or abnormal neurologic signs) mild but significant brain injury can go unnoticed, especially in children, and can lead to subtle but significant difficulty later on.²

The financial and emotional impact of TBI can be devastating for both people with brain injuries and their families. Because people with brain injuries are typically young adults, the loss of productivity and jobs over the normal life span is enormous. A person with a severe brain injury may amass \$436,000 in medical costs and additional annual costs of \$32,000 to \$63,000 for rehabilitation and ongoing medical expenses.¹

The Injuries and Preventive Measures

Motor vehicle crashes cause one-half of all TBI. In the United States, some 2.7 million people per year, or more than 9,000 individuals per day, may suffer significant brain injury from motor vehicle crashes.³ About 40,000 people die in motor vehicle crashes each year and 63% of all injury deaths to children and teens in the United States are motor vehicle related. Teens and infants are the most vulnerable populations. Brain injury is also the leading cause of death in motorcycle crashes.

Brain injury, unlike many other illnesses, can be prevented in many instances. Physician counseling should include the following advice for reducing the risk of brain injury:

- Wear safety belts. The single most important method of preventing brain injuries from motor vehicle crashes is the use of safety belts. They are 57% effective in preventing fatal or serious injuries. In other words, an individual's chances of survival are more than doubled by the use of safety belts.
- Use a child restraint device to protect small children under age 4.
- Never drink and drive.
- Use helmets. The single most important variable determining survival for motorcycle crashes is the use of safety helmets.³ Motorcyclists who do not wear helmets have a 27% greater chance of dying than those who do.

From the Tennessee Department of Health, Nashville. Ms. Doster is director of the Traumatic Brain Injury Program.

Falls account for 21% of all TBI. Falls are the primary source of head injury in children, and account for about 60% of the injuries.³ Falls are second only to motor vehicle crashes as a leading cause of brain injury in the elderly.

Counseling advice:

- Use energy-absorbing playground surfaces or loose materials such as wood chips or sand. Swings should be made of rubber, plastic or canvas, and have rounded edges and a smooth finish.

- Keep stairs safe by clearing them of toys, laundry, etc. Remove or repair loose carpeting or treads. Use net gates at stairs.

- Install nonskid surfaces in the tub.

- For individuals unsteady on their feet, encourage the purchase of sturdy shoes.

Assaults and violence account for 12% of all TBI. More than 2.2 million people annually suffer nonfatal injuries from assaultive violence.³ Child abuse, including shaken baby syndrome, accounts for 64% of infant brain injuries. Abuse-related brain injury is the leading cause of death in children under the age of 2.

Counseling advice:

- Avoid places where there is risk of assault, e.g. "rough" bars.

- Keep firearms stored, unloaded, in a locked cabinet.

- Discipline your child with caution and restraint, avoiding physical means. Even mild shaking can damage a child's brain. Never shake or strike a child.

Sports and recreational activities account for 10% of all TBI. Head injuries are the primary cause of death in 75% to 80% of all cyclist fatalities; 20% to 24% of all pediatric head injuries are due to bicycle riding.² Brain injury rates are highest among boys aged 10 to 14. An important source of bicyclist head injuries that has not received much research attention is the bicycle-mounted child seat.

Since 1980, over 1,000 persons have been killed and some 340,000 persons injured in all-terrain vehicle (ATV) mishaps. The American Academy of Pediatrics has termed ATVs a serious hazard to the health and well-being of children.³ Mini-bikes, trailbikes, skateboards, roller-blading, and equestrian sports have all been implicated in brain injuries in adults and children.

Counseling advice:

- Use helmets. Purchase safety helmets that meet or surpass American National Standards Institute (ANSI) and the Snell Memorial Foundation standards. Use a helmet when riding a bicycle of any type as well as when skateboarding, roller-blading, or horseback riding.

- Bicycle helmets are 85% to 88% effective in mitigating total head and brain injuries. Children can be encouraged to

wear helmets if their preferences are considered. Color is an important determinant of helmet preference; black is most frequently selected, white least frequently. Helmet design and styling are important; helmets with hard plastic shells are preferred over soft-shell models. Children need to be reassured that their peers consider wearing helmets "smart."

Who Needs this Information?

In terms of who sustains TBI, boys and men aged 14 to 24 are at highest risk, followed by infants and the elderly. Children are at risk as well, especially in the afternoon hours after they are dismissed from school. Therefore, patients of all ages—parents, children, teens, and seniors—will benefit from brain injury prevention information.

For information on sources of age-appropriate brain injury prevention materials for in-office use, contact the Tennessee Traumatic Brain Injury Program at (800) 882-0611. □

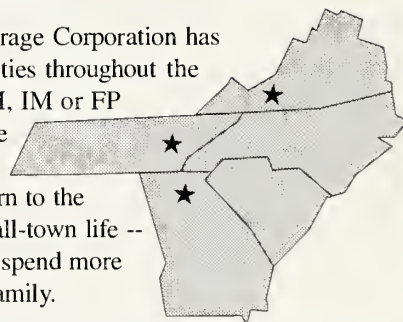
References

1. Wright B: *What Legislators Need To Know About Traumatic Brain Injury*. National Conference of Legislatures, 1993.
2. Swain A: *Environmental Risk Factor in Childhood Head Injury*. National Head Injury Foundation, Inc, 1989.
3. Templer D, Hartlage L, Cannon W (eds): *Preventable Brain Damage, Brain Vulnerability and Brain Health*. New York, Springer Publishing Co, 1992.

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TMA Alliance Report

Dollars Can Make an Impact

In this year of health care wars and budget cuts we need to ensure that we have elected candidates sympathetic to medicine. IMPACT funds can help us to reach that goal by providing the all-important financial dimension to medicine's voice in Nashville. Are you aware that none of your TMA and TMAA dues can be contributed to political campaigns?

It is imperative that now, more than ever, physicians and their spouses keep aware of the legislative issues at hand. To decide which candidates will get IMPACT funds, an appointed board of directors thoroughly investigates each prospective candidate. Voting records are researched, personal interviews are held, and knowledgeable political sources are consulted. Your membership allows IMPACT to build strong relationships with medicine-friendly legislators, enabling physicians to concentrate on the task at hand—providing quality care for their patients. Please support IMPACT by sending you personal checks to:

IMPACT, P.O. Box 120909, Nashville, TN 37212-0909

This is a particularly exciting election year for the state of Tennessee. We have three physician spouses running for elected office.

Shirley Duer (R), wife of Dr. Carl Duer of Crossville, is running for a Senate seat in district 12. She has been a Representative to district 12 since 1980.

Mary Ann Eckles (D), wife of Dr. George Eckles of Murfreesboro, is running for her second term in the House of Representatives in the 49th district.

Rosalind Kurita (D), wife of Dr. George Kurita of Clarksville, is running for the Senate seat in district 22.

The 1996 election gives us the opportunity to have a strong voice in Nashville.

Sue Vegors
TMAA State IMPACT Chairman

Goals 1996—Why We Matter

Within the first few months after the November 1994 election, a newly elected age group helped steer a course of reform unprecedented in this century. Yet their chosen instrument of change is not just found in our elected officials, but it is the reflection in the power of grassroots organizations.

All across America these grassroots movements are creating new voices and new ideas. Not just passive observers, but powerful advocates of their views. Little did any of us realize the outpouring there was on a national and local level.

Here in Tennessee, the TMAA plans to be in the forefront of these efforts in the pursuit of a quality health care system for physicians and patients. Following are our legislative goals for the upcoming year:

- *Improve Communication.* Getting our message out is paramount in making our goals happen. Of the many ways we can reach our officials, one form we take for granted is a personal letter. This is a powerful tool in recruiting and energizing people.
- *Rebuild.* Rebuild our grassroots support for key medical

legislation.

- *Recruit.* Recruit all new and old alliance members. We are all key members in our mutual goals.

- *Educate.* Educate our high school and university students on the value and responsibility of voting, encouraging the teaching and learning of the fundamental electoral process.

One lesson we have learned is that we cannot change health care through one big legislative "fix." Instead, by sensibly building one block at a time, we stand a better chance of making dramatic improvements in health care.

Linda Knabb
TMAA State Legislative Chairman

Letters to the Editor

Loss Prevention

To the Editor:

This letter is about "Who/Where Is My Doctor?" in the August issue of *Tennessee Medicine* (*Tenn Med* 89:286-287, 1996).

The disclaimer in italics underneath Dr. Avery's photo robs this article of any relevance or teaching use it might have had.

First. As written, I can't tell what's fiction and what's fact. This is the author's aim. Physicians are *not* idiots; they are taught to read and to learn. They do.

Second. If this is an "insurance article," all that need be said is: It's cheaper to settle than litigate. After excess verbiage, Dr. Avery says that.

Third. The legal profession has several formats for elucidating the legal aspects of a case. One of them sets forth the *issues; the relevant fact situation; the applicable law; an analysis, if needed; and conclusions.*

Such a format has been used for many years, which attests to its utility.

I might point out that the case in the August '96 issue was about a lawsuit, which means it is "on public record" which means anyone who chooses can read it. Although Dr. Avery's feelings for the defendant are commendable, the law has already stripped the defendant of his anonymity. The author's attempt is pointless.

I would like to recommend that an *attorney* at SVMIC or elsewhere write the appropriate article in the proper form. This will instruct your readers more fully and more adequately.

Charles W. Quimby Jr., MD
5247 Old Harding Road
Franklin, TN 37064

Response

There seem to be two issues in this letter that should be answered. The first is the reference to the format used by attorneys to present the legal aspects of a case. It has never been the aim of the "Loss Prevention Case of the Month" to be a legal presentation. Rather, the effort is made to present the clinical setting in such a way that the reader might deduce the reasons

the physician was sued in the first place and try to avoid such behavior in his own practice.

The second issue in the letter is a reference to the disclaimer which is placed at the beginning of the article. There is an attempt to fictionalize the case to the extent that the physician whose case it happens to be is less likely to be embarrassed by the recognition of the case by himself or a colleague.

J. Kelley Avery, MD
P.O. Box 159012
Nashville, TN 37215-9012

TMA Board of Trustees Meeting Minutes

July 13-14, 1996

The following is a summary of the major actions taken by the Board of Trustees of the Tennessee Medical Association at its regular third quarter meeting.

The Board, staff, and guests honored the memory of Dr. Thomas K. Ballard Jr., TMA past president, who had passed away July 9, 1996, with a moment of silence.

The following agenda items were placed on the consent calendar: (1) Response to Resolution No. 27-96 "Medical Class Action Lawsuit Against the Tobacco Industry." (2) Endorsement of Breast & Cervical Cancer Program. (3) Endorsement of AIDS Screening Program. (4) Quarterly report of TMA Physician Services, Inc.

THE BOARD:

Approved Minutes. Approved the minutes of the April 11 and April 14, 1996 meeting as distributed, and approved the minutes and confirmed the actions of the Executive Committee meeting held May 29, 1996.

Strategic Plan. Received a report from Mr. Alexander on the progress of work performed by TMA staff concerning the Strategic Plan.

Contract Review Service. Received a report from Mr. Overlock on the response to the request for proposals for health care contract reviews. The Board deferred action on the selection of a firm to the Executive Committee.

Annual Meeting Committee. Received a report from Mr. Grant on the progress of the 1997 "48-Hour" Annual Meeting to be held in Chattanooga, April 11-12.

Ritalin Study Nominations. Deferred action to the Executive Committee for the submission of names for consideration of appointment to the special house study committee on Ritalin.

TMA Interspecialty Advisory Council. Deferred action to the Executive Committee to submit names for consideration of appointment to the newly formed TMA Interspecialty Advisory Council.

TMA Committee Appointments. Reappointed Dr. Cynthia Youree, Brentwood, to serve a two-year term on the Commit-

tee on Continuing Medical Education. Appointed Dr. Neal Beckford, Memphis, to serve as chairman of the Committee on Managed Care, and appointed the members currently serving on the Managed Care Task Force to serve as the committee members. Deferred action to the Executive Committee to appoint members to the newly formed Committee on Practice Management. Appointed Dr. Charles Jordan III, Cookeville, to serve as chairman of the Interprofessional Liaison Committee.

State Appointments. Agreed to submit the names of Drs. Jesse C. Woodall Jr., Memphis; Frank H. Boehm, Nashville; and Samuel D. Evans, Maryville, for consideration of appointment to the State Perinatal Advisory Committee.

Quarterly Reports. Received written quarterly reports from SVMIC and IMPACT.

Report from the Tennessee Delegation to the AMA. Received a report from Dr. Allen S. Edmonson, Memphis, chairman of the Tennessee Delegation to the AMA, on the actions taken by the AMA House of Delegates at its Annual Meeting in Chicago.

Governmental Medical Services and Third Party Payors. Referred the report presented by the Committee on Governmental Medical Services and Third Party Payors back to the committee for further deliberation.

Managed Care Seminars. Approved the recommendations submitted by Mr. Miller for proposed managed care seminars to be held in various locations of the state.

Board of Dentistry Ruling. Received a report on a recent ruling made by the Board of Dentistry that "esthetic" encompasses cosmetic surgery.

Membership Surveys. Agreed to consider an outside source for a membership survey, and directed staff to present proposals for the cost of conducting such a survey to the Executive Committee.

Workers' Compensation Advisory Committee. Confirmed the actions of the TMA president, Dr. Richard M. Pearson, supporting the consideration of Drs. Fred Killeffer, Knoxville; William R. Stewart III, Nashville; and Ron Bingham, Jackson, for consideration of appointment to the Workers' Compensation Advisory Committee.

Board of Medical Examiners. Received a report from Mr. Greene that Governor Sundquist had appointed Dr. David O'Neal, Chattanooga, and reappointed Dr. Daniel Starnes, Nashville, to the Board of Medical Examiners.

Clinical Oversight Committee for TennCare Partners Program. Agreed to submit the name of Dr. Robert Neaderthal, Nashville, for consideration of appointment to the Clinical Oversight Committee for TennCare Partners Program.

TMA Antitrust Policy. Adopted an antitrust compliance policy along with a TMA Board of Trustees general rules of antitrust compliance.

Second Quarter Financial Statement. Received a report from Dr. James Chris Fleming, TMA secretary/treasurer, on the finances of the TMA through the second quarter. □

In Memoriam

William M. Bielskis Jr., age 57. Died March 13, 1996. Graduate of University of Tennessee College of Medicine. Member of Memphis-Shelby County Medical Society.

William E. Elliott, age 69. Died July 2, 1996. Graduate of University of Washington School of Medicine. Member of Blount County Medical Society.

Charles K. Gardner, age 83. Died July 26, 1996. Graduate of Baylor University School of Medicine. Member of Nashville Academy of Medicine.

Irving R. Hillard, age 83. Died July 23, 1996. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Paul Ramsey Michael, age 47. Died August 15, 1996. Graduate of University of Florida College of Medicine. Member of Nashville Academy of Medicine.

Daphne Sprouse, age 71. Died August 3, 1996. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

Jean C. Tarwater, age 72. Died July 3, 1996. Graduate of University of Tennessee College of Medicine. Member of Knoxville Academy of Medicine.

M. Clarke Woodfin Sr., age 88. Died July 31, 1996. Graduate of Vanderbilt University School of Medicine. Member of Nashville Academy of Medicine.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

BENTON-HUMPHREYS COUNTY MEDICAL SOCIETY

Denis A. Harlock, MD, New Johnsonville

BLOUNT COUNTY MEDICAL SOCIETY

Carole L. Long, MD, Maryville

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

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Randy R. Heisser, MD, Chattanooga

Larry D. Howard, MD, Chattanooga

Edwin T. Hulse, MD, Ft. Oglethorpe, GA

Joseph Kipikasa, MD, Chattanooga

Tamunosaki E. Lawson, MD, Chattanooga

Eric Mayer, MD, Chattanooga

Michael C. Mena, MD, Chattanooga

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Albert K. Holmes, MD, Knoxville

Thomas R. Pollard, MD, Knoxville

D. Skip Saltee II, MD, Knoxville

Charles B. Treasure II, MD, Knoxville

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NASHVILLE ACADEMY OF MEDICINE

Robert L. Chalfant Jr., MD, Nashville

NORTHWEST TENNESSEE ACADEMY OF MEDICINE

Gurpal S. Bindra, MD, Dyersburg

ROANE-ANDERSON COUNTY MEDICAL SOCIETY

Naresh R. Mistry, MD, Oak Ridge

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during July, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Jack R. Baker, MD, Nashville

Robert F. Baker, MD, Sparta

Benjamin F. Byrd Jr., MD, Nashville

David L. Cunningham, MD, Memphis

Thomas S. Dake, MD, Columbia

Deborah C. German, MD, Nashville

Robert L. Haley, MD, Nashville

Elbert E. Hines, MD, Bartlett

Dabney James, MD, Chattanooga

Stephen S. Kim, MD, Cleveland

Sarma R. Kunda, MD, Chattanooga

Harry M. Lawrence, MD, Chattanooga

John R. Lorenz, MD, Greeneville

Donald R. Lovelace, MD, Kingsport

Lawrence D. Lubow, MD, Hendersonville

Harold A. McCormack, MD, Memphis

Douglas P. Mitchell, MD, Nashville

Eric D. Moffet, MD, Kingsport

Jon M. Owings, MD, Pulaski

Frances K. Patterson, MD, Knoxville

John B. Phillips, MD, Parsons

Ann H. Price, MD, Nashville

Frank W. Stevens, MD, Nashville

Richard B. Stewart, MD, Nashville

Marion B. Tallent, MD, Brentwood

William S. West, MD, Nashville

Winston H. Worthington, MD, Knoxville

Personal News

Richard L. Breeden, MD, Tullahoma, has been certified as a Diplomate of the American Board of Sleep Medicine.

Robert C. Collier, MD, Tullahoma, has been certified as a Diplomate of the American Board of Ophthalmology.

Eddie Joe Reddick, MD, Nashville, has received the American Society of Abdominal Surgeons Distinguished Service Award for his pioneering work in laparoscopic cholecystectomy.

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

Special Conferences/Seminars

Detailed brochures for the following courses are available. In some cases, registration numbers are limited.

- Oct. 18-19 Laryngeal Video Endostroboscopy Workshop
- Nov. 13-16 2nd Neonatology Symposium—Asheville, N.C.
- Dec. 6-7 22nd High Risk Obstetrics Seminar

For information contact Division of CME, Vanderbilt University School of Medicine, D-8211 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

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University of Tennessee

Continuing Education Schedule

Memphis

- Nov. 1-2 15th Gynecological Surgery Seminar
- Nov. 4-8 Advances in Medicine—Maui, Hawaii
- Jan. 9-11 High Risk Perinatal Seminar
- Feb. 17-20 Update in Obstetrics & Gynecology—Grand Caymen Island
- Feb. 23-28 Clinical Medicine—Kauai, Hawaii
- March 6-8 Symposium on Critical Care & Emergency Medicine—Hot Springs, Ark.
- March 8-15 Current Issues in OB/GYN—Snowmass Village, Colo.
- March 16-22 30th Review Course for the Family Physician

Knoxville

- Nov. 6-8 Advanced Cardiac Life Support Course
- Nov. 15-16 New Concepts in the Treatment of Cardiac Disorders
- Dec. 3-5 Perinatal Update '96—Gatlinburg
- April 23-25 20th Family Practice Update & Review—Gatlinburg

Chattanooga

- Dec. 5-6 Cardiology
- Feb. 23-26 Clinical Medicine—Kauai, Hawaii
- March 7-8 Allergy & Immunology
- March 20-21 Pediatrics

For information contact Mrs. Jean Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163, Tel. (901) 448-5547.

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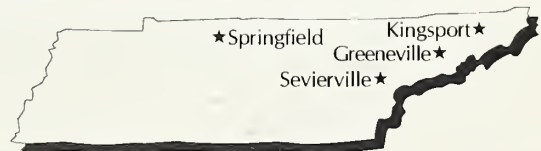
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List of Advertisers

Astra Merck	368
Carolyn Avery & Associates, Inc.	384
Dodson Insurance Group	367
DuPont Pharma	387
Emergency Coverage Corporation	379
First Tennessee Bank	350
HealthLine Management	371
Jeremy Cay, Edisto Island	352
Nashville Neuro-Pain Corporation	375
Rural Health Services Consortium	385
State Volunteer Mutual Insurance Company	388
Team Health	385
Tennessee Consultation Center	354
TN Dept. of Mental Health/Mental Retardation	380
U.S. Air Force Reserve	386
U.S. Army	377
U.S. Army Reserve	364
Vanderbilt's Owen Graduate School	366

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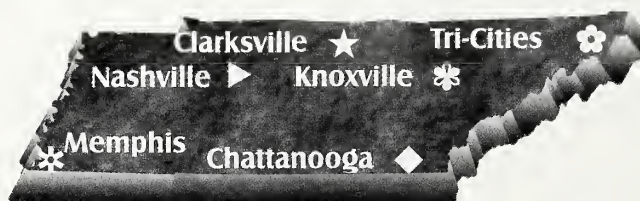
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Richard M. Pearson, MD

Thank You

Great words, trivialized by inappropriate, insincere usage, are numerous. Every bill, statement, cash register receipt, restaurant menu, and prepackaged hamburger has these words printed on them. The message, of course, is not from the heart.

Giving thanks, when it is from the heart and doesn't hope for any secondary gain, is like prayer. The very act benefits the giver regardless of the gift. Giving thanks, however, cannot only fall victim to overuse and trivialization, but it can fall victim to neglect. We come to expect many things for which we should be thankful, and we may recognize their great value only when they are taken away.

This year we physicians should be thankful for *friends*. Friends of doctors and of medicine can be hard to come by these days. Let me point out a few groups of your friends and urge you not to neglect them. Be sure that you thank them in whatever sincere way is most appropriate for your relationship.

What separates medicine from herbalism and psychic healing and witch doctors is that our profession is predicated on scientific knowledge and research. In the field of health care there is another prominent profession whose premise is based on scientific knowledge and that is the profession of nursing. I am not speaking here of course about the nurse manager or the utilization review expert whose primary goals are promoting corporate culture and increasing the bottom line. I am speaking here of the nurses that you and I work with every day in our offices, in hospitals and in patients' homes, who have the same vision of humanity that we have: doing good for people who are sick. These nursing professionals are facing the same types of problems that physicians are confronting and they are struggling to find ways to deal with the problems and still maintain professionalism and good patient care. These nurses need an ongoing "thank you" from us. They likely are not getting it from anywhere else in their professional lives.

The second group that we must openly thank for being our friends are those business and legal professionals who truly believe in what physicians are doing to preserve patient-oriented, personal, one-on-one health care. Not everyone is against us. These people are truly our friends. They, like us, are experiencing the discomfort, upheaval, and displacement associated with the changes in health care delivery and financing. They include your office staff and the staff of all the physician-oriented professional associations that serve you: local, state, and national professional associations, physician-owned insurance carriers, professional management associations, and others.

Your friends also include most of your patients. They want you to continue to be their doctor and they don't want anything or anyone to interfere in their care. Because all of our friends are also patients of some physician, they carry with them a small part of your vision of health, sustained by caring and not by cost reduction.

Especially now, thank your friends and support them. They are supporting you. This season let "the still, small voice of gratitude" be yours.

R. Pearson MD

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John B. Thomison, MD

HMOs—The Latest Revisitation

I read the other day that in the last decade health care expenditures in this country have doubled from a half-trillion dollars to one trillion dollars. During that same time the HMOs and managed care organizations (MCOs) have been proliferating, ostensibly to save money. This interesting bit of information, considered in light of the way investors have been flocking to such equities, supports, even confirms, my contention that HMOs do not save money. They simply redistribute it. They redistribute it to please their stockholders, else they have no stockholders, which is the root of the problem. (As the Apostle Paul explains, *the love of money*—not the money itself—is the root of all evil.)

Those of us in the business of caring for patients, about whom the investors care not a fig—neither the patients nor us—unless of course their own ox is being gored in the process, have ample evidence that this bonanza to the investors is accomplished at the expense of patient care. Your Tennessee Medical Association has been and is doing all in its power to subvert the operation of the HMOs and MCOs as it presently exists because of the deplorable sequelae of their unconscionably misanthropic, self-serving, avaricious corporate philosophy, so as to force them into giving some even slight consideration to ethical, and even legal, patient care.

I suspect some of you rabid die-hard Vandy fans, if before you read this you had inspected some other parts of this issue, are already accusing me of having sold out to the Philistines—translate: the University of Tennessee. Before you do, though, consider that the TMA is doing its level best to accomplish its previously described mission in a manner most sparing of your precious dues dollars. (If you don't know what I'm talking about, you need first to read Russ Miller's piece entitled "Teaming up With UT Football: TMA's 1996 Radio Campaign.") In the first place, it is vastly less expensive to polybag the brochure with the *Journal* than to have a separate mailing. In the second place, it is vastly less expensive to piggy-back our own brief message to the public via the Vol network than to get the word out to so many people in any other way. (In case you haven't noticed, there are *lots* of UT fans out there.)

Being practical folks, I'm sure you Vandy fans will understand, first being as my immediate family has between us six Vanderbilt and no UT degrees, and many of you have, despite your Vanderbilt degrees, some UT ones thrown in, either yourselves or some other family members, which I'm sure bothers you not in the least. The other comment I would make is that you are all Tennesseans, and, despite what the orange and white may do to the blood pressure of some of you on a given Saturday afternoon once a year, UT *is* your state school.

I have to say that this commentary is merely prophylaxis, and I didn't *really* expect to encounter any flack. But then as any airman knows, it is the unexpected flack that has always proved the most deadly. Our common enemy is the unbridled HMO and MCO.

Sic 'em, Phido!

Thanksgiving

Expressing thanks for favors rendered is one of the niceties distinguishing the civilized being from the barbarian. Expressing gratitude is not necessarily the same thing, since animals other than human show evidence of gratitude. Indeed, civilization is a relative term. Certainly those in the so-called, or perhaps better, self-styled, civilized countries often show little evi-

dence of it, acting as they sometimes do with gross disregard for the life, limb, and property of their fellows. Maybe the distinction is that they do it with finesse, at least sometimes. Western civilization considers itself the epitome, yet at any given time there is and always has been something going on somewhere in the world to which Western civilization is a party that makes it hard to convince any thinking person of it—or often to notice even any finesse.

Perhaps it is just that as we look about us the comparisons convince us that we are better—i.e. “more civilized”—than “they” are. If that is so, our self-congratulatory posturings merely damn us with faint praise. Those who recognize this human failing without recognizing that any veneer of civilization is very thin indeed in even the most polished may well lose the ability to see the comical side of the human condition, or else if they recognize the general defect without recognizing it in themselves, they will almost certainly develop an insufferable spiritual pride and arrogance.

Arriving on the shores of New England at, or some now tell us only near, Plymouth, Mass. in wintertime after a deadly voyage from Europe during which many of their number had died, with the help of friendly Indians the surviving members of this little band of victims of religious oppression managed to eke out an existence until the following summer, following which they were blessed with an ample harvest. If the Puritans really were, as often depicted, a stern and joyless group, it is strange that they were able to win the friendship of the Indians, and to share with them a joyful feast of thanksgiving to God for the bounteous harvest and their own survival.

If they have seemed joyless to their historians, and to us, perhaps it is just that as a group their joy was otherwise directed, and it is also not unlikely that some of them might have disapproved of the activities and desires of those of unlike inclinations. The Lord's Day was just that, and was spent largely in the meeting house, which was doubtless tedious, especially for some of the younger of them. My friend and mentor John L. Shapiro, MD, who grew up in a Church of Christ where long sermons were the norm, stoutly maintained that very few souls are saved after 20 minutes, and Hester Prynne might have been a casualty of such rigors. I noted the other day that to appeal to some of the younger disaffected Jews in the community a synagogue here in Nashville, likely in company with others elsewhere, was offering an abbreviated one hour celebration of Rosh Hashana across the hall from the traditional five-hour one. I think this is symptomatic of the short attention span fostered by channel surfing on the tube.

We in this country have so many things, and too often we fail to recognize their source. Each one of us came into the world through no thought or action of our own. Though I was conceived through the union of my parents, nothing they did resulted in my being born instead of another person. It was not my decision to be born in Tennessee in 1921. Opportunities were given me that were not of my making. The best I could do was take advantage of them when they were offered. I sometimes did, but more often let them slip away. Neither did I earn the means to do so; they were also given me. Countless others aided me, some of them known to me, but many more likely not. Tennyson had his Ulysses say, “I am a part of all that I have met.” Yes, and much, much more. The hero of William Earnest Henley's “Invictus” says, “I am the master of my fate, I am the captain of my soul!” Tommyrot and Balderdash!

In the dark days of the late unpleasantness between the States, President Abraham Lincoln proclaimed a national day of thanksgiving to God on the last Thursday of November “for the Union.” Congress later made this a permanent national holiday, and we celebrate it each year. It is widely referred to as “turkey day,” with little thought about for what or to whom it is we are to be thankful.

You may not like our President, but aren't you glad you have the freedom to say so? And to try to vote him out? If you fail, you are free to try again. You are free, if you wish, to renounce your citizenship, and take up residence elsewhere, if that is your wish. Think about all you have to be thankful to God for, and then thank Him. It is one of the niceties that separates us from the barbarian, who in days past just might have sacrificed his first born. Aren't you thankful you have the freedom not to? □

Special Communication

Teaming Up With UT Football— TMA's 1996 Radio Campaign

Russ Miller, TMA Senior Vice-President—Communications and Membership

To coin a very popular phrase 'round here in the fall—"It's football time in Tennessee!"

As in years past, TMA has teamed up with the Vol Radio Network (Host Communications) to sponsor the University of Tennessee Football games every Saturday. 1996 marks the third year TMA has worked with the Vols.

Our message this year is "Trust your health to someone who learned medicine from a medical book, not a check book." Based on this concept, we developed two radio announcements, a full page color advertisement (featured on the cover of this month's *Tennessee Medicine*), and a patient brochure on managed care.

Also included as a supplement to this month's *Tennessee Medicine* is the original artwork for an informational brochure on managed care designed for patients. The brochure is entitled "Managed Care—Who Calls the Shots?" and is for members to use to make reproductions for their patients. If you need more original copies, simply call the TMA at 800-659-1-TMA.

Some members may ask "Why is TMA sponsoring UT football games?" The decision is a simple one. At any given point on a fall Saturday afternoon in Tennessee, roughly 20% of the state's citizens are tuned in to the UT game. After an exhaustive search, we could find no other medium that reached the various target groups that represent TMA's message audience.

TMA Radio/Managed Care :30 seconds

"Did you know medical decisions are not always made by doctors?"

That's right. In today's emerging managed care system, medical decisions are often made by business people trained to save dollars, not lives.

The Tennessee Medical Association believes that is hazardous to your health.

If you are considering a managed care plan for family or employees, call the TMA at 800-659-1TMA for a free brochure about managed care.

Health care should be based on medical books—not check books.

A message from the Tennessee Medical Association."

—Vol Radio Network
August, 1996 - January, 1997
90+ affiliate stations

Since the beginning of the CARE program in 1989, TMA's target audience has remained patients (general public), physicians (members and nonmembers), the media, health care decision makers, civic leaders, and lawmakers. To reach all these folks through their individual medium of choice is prohibitively costly. The Vol Radio Network offered the TMA one-stop shopping at a reasonable price.

To increase the effectiveness of the 1996 campaign by increasing our chances of reaching those who don't listen to UT games, we have also purchased prime time air space on the Tennessee Radio Network, which includes 90 stations statewide, both urban and rural. This portion of the campaign is running from October 7 through Oc-

tober 30, the time when health care decision makers choose plans for the upcoming year. By the end of October, TMA's message will have aired more than 2,500 times!

While TMA is getting the word out about managed care, physicians have to do their part, too. Encourage your patients to ask you about certain health plans before enrolling or changing plans. Provide them with a copy of the TMA brochure highlighting questions to ask about a health plan. Make time to help your patients make important decisions about their health care—remember, it's important for them to trust their health to someone who learned medicine from a medical book, not a check book. □

Loss Prevention Case of the Month

Negligence in a Good Practice

J. Kelley Avery, MD



Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

Twenty years prior to this admission, a 70-year-old woman had a total arthroplasty of the right hip because of a non-union of a fracture of the femoral neck. She did well for approximately ten years, but because of severe pain and disability in the hip brought on by loosening of a component of the prosthesis, she required a revision of the procedure. Again she did well for about ten years before she again began to have disabling pain in the hip, again requiring surgical attention.

Three years before this admission the patient had bouts of superficial thrombophlebitis, for which she had been maintained on Coumadin. She had hypertension, which was well controlled. In the past she had had pelvic surgery and had been receiving maintenance estrogen therapy for many years. She was admitted this time for a total revision of her hip prosthesis. She had stopped taking the anticoagulant about a

week earlier and had received clearance for the surgery by an internal medicine specialist.

The surgery was uneventful, and the patient did well considering the magnitude of the operation. Postoperatively, she received prophylactic heparin and Coumadin. Three and five days after surgery, the internist noted the prothrombin time (pro-time) was "sub-therapeutic," and the Coumadin was increased from 2.5 mg, which had been the daily dose during

the heparin administration, to 5 mg daily. Six days after the operation, the patient was reported by the internist to be "stable," and the heparin was stopped. Two days later, the patient developed some calf tenderness, and a venous sonogram was done; it was reported as normal. The patient was walking with minimal assistance and a walker at this time. She was discharged home two weeks after the operation. The internist noted three days before discharge that the control pro-time was 11.6 seconds and the patient 13.1 seconds, indicating that the anticoagulant was moving up toward the desired therapeutic level. On the day of discharge, the internist phoned in the take-home orders, which included continuing the Coumadin at 5 mg daily. She was given an appointment to see both her orthopedist and her internist four weeks after discharge.

She returned for these appointments and the internist found her to be making good progress with her home physical therapy. She did complain of easy bruising, and the Coumadin was stopped. Laboratory data on this visit showed that the hematocrit was 34.4% and the control pro-time was 12.5 seconds and patient 35 seconds. She had 2+ blood in her urine (2 to 4 RBC/HPF uncentrifuged).

The following day the patient began to have pain in her neck and back, and became extremely weak, diaphoretic, and dyspneic. She was admitted to her hometown hospital, where admission laboratory studies showed the hematocrit to be 18.2% with a hemoglobin of 6 mg/dl. The pro-time was calculated at 86.1 seconds for the patient and 12.5 seconds for the control. She was in heart failure. The CT of the abdomen and back showed extensive retroperitoneal hematoma. She had massive hematuria and bleeding from the GI tract on admission. She required six transfusions of packed RBCs and treatment for heart failure. She remained hospitalized for one week, most of that time being in the ICU, and was discharged home weak but recovering.

The details regarding just why the patient filed a lawsuit are not known. One can safely assume that it was apparent to the patient and her family that the anticoagulant was not properly managed. To require readmission to a hospital within the first 24 hours after the first post-hospital visit to her physician with massive blood loss would be enough to question the care she received. It is possible that the lawsuit was filed

in order to find out the reasons why the patient was allowed to get so far out of control with the anticoagulant.

Loss Prevention Comments

The investigation of this case following the filing of the lawsuit revealed that at the time of discharge from the hospital following the hip surgery, the internist intended to instruct his patient to have her blood tested at weekly intervals. There was no documentation to this effect, and the nurse who took the phone orders for discharge had carefully written the entire medical regimen, including all the medications and the correct dosage of each, and the instructions for physical therapy and exercise. One would have to conclude that if the internist had ordered the frequent blood tests, those instructions would have been included along with the others.

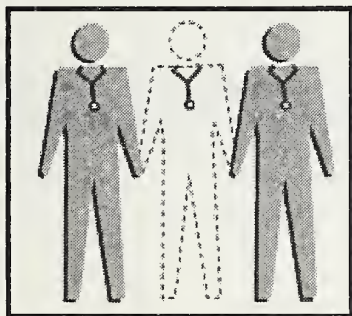
It was also found that the internist did not know that the capability of his laboratory was such that 35 seconds was the maximum time the pro-time machine would measure. That being the case, the surveillance of the pro-time was not only in error, but the determination of the pro-time on her return

to the physician's office was wrong.

Although the patient recovered, the complications she suffered were life threatening, and the pain and suffering occasioned by the retroperitoneal hemorrhage and the congestive heart failure were significant. The monetary loss of an additional week of hospitalization, including the days in the ICU, was also a factor.

Questions could be asked in the aftermath of a case like this. If the internist had returned to the hospital and personally discharged his patient, would he have recognized the need to be more explicit about the need for weekly blood tests until he saw her in his office? I believe that he would. He certainly could be expected to know the capabilities of his own office laboratory. Was he new to the practice in this office setting? Was he not properly oriented to the office systems, so that this mistake could have been avoided? Was this a new machine with which he was not familiar? Nobody thinks that this physician's negligence was deliberate, but negligence it was, and it threatened the life of his patient. It also required a monetary settlement. □

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'96 Elections

Campaigning in Cyberspace

At the end of the 19th century, a modern presidential campaign meant crossing the continent in a train, taking the political message to the cities and farms across America. In the middle of the 20th century, radio and television ensured that every American within viewing and listening radius was able to hear the debates and speeches of the national candidates.

At the end of the 20th century, we've turned yet another corner in the practices of modern political campaigns as candidates for everything from the presidency to the county clerk take to the information superhighway in an effort to attract votes.

There are more than 4,000 web sites available on politics and government. These sites cover every political affiliation from the far left to the far right, and everything in between.

The most positive aspect of this proliferation of campaign sites is that Americans have more information than ever available at their fingertips. More information means a more educated choice, which in turn increases the level of participation among the electorate.

Use one of the many popular search engines, or point your URL address to <http://www.voter96.cqalert.com> to increase your political IQ. This site, maintained by Congressional Quarterly, one of the leading nonpartisan periodicals in the country, is a launching point to unlimited political sites, for

everything from the Democratic and Republican National Parties to the home pages of the Presidential candidate, to checking up on your local U.S. House race.

Visit your favorite candidates to get their views on the issues. The national parties generally have links to their candidates, or you can access candidate information via the Congressional Quarterly site. To visit the presidential campaigns, key in the site of campaign—<http://www.dole96.com> for Dole for President or <http://www.CG96.org> for the Clinton-Gore '96 Committee.

To access one of the national party committees, key in <http://www.democrats.org> for the National Democratic Party, or <http://www.rnc.org> to visit the Republican National Committee's site. Or if you'd like to visit the newest American political party, key in <http://www.reformparty.org> for the Ross Perot's National Reform Party.

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As you approach election day in November, don't forget to use the latest tool available to the politically active medical community—your computer. □

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Crossing a Patient's Sexual Boundaries

Marc E. Overlock, TMA Senior Vice-President and General Counsel
Robert J. Gonzales, TMA Staff Attorney

"The public, as patients, necessarily place considerable trust in doctors for their highly specialized knowledge of the healing arts. This trust is engendered by the influence over the patient unique to the medical profession. Medical doctors, if unscrupulous, are in an extraordinary position to abuse any weakness or vulnerability in their patients."¹

One need not look far in the medical, scientific, or legal literature² to find discussions and examples of physicians and other learned professionals violating patient trust by means of sexual abuse. The ramifications of sexual misconduct can be personally and professionally devastating. Tennessee courts have taken notice,³ as have both the Board of Medical Examiners (BME)⁴ and the General Assembly.⁵ This article examines how physicians run afoul of Tennessee law by engaging in sexual misconduct, and reviews some strategies physicians can use to avoid such trouble.

Certain forms of sexual abuse that occur within the physician-patient relationship are so outrageous that they are easy to recognize and are universally condemned. Examples include sexual intercourse, oral sex or fondling a patient's genitals, perpetrated by force, under the guise of treatment or as part of an examination. Penalties for such conduct are severe, usually including revocation of the perpetrator's medical license, as well as substantial fines. Lawsuits and criminal sanctions often follow, to say nothing of the absolute and utter public humiliation the physician, and in some instances, the patient face.

The court cases and scientific literature, of course, offer the reader extreme examples, and, hopefully, are really not an issue for most physicians. Even the most conscientious physician, however, needs to be aware of sexual boundaries with patients because the boundaries are not always as clear-cut as one might expect. Some patients may view sexual misconduct differently than their physicians, and penalties can be personally and professionally devastating even when the accusation appears groundless to a reasonable physician.

What is Sexual Misconduct?⁶

The BME defines sexual misconduct⁷ as "sexual contact between a physician and a patient." What, then, is sexual con-

BME RECOMMENDATIONS

1. Be alert to feelings of sexual attraction with patients and consult colleagues for feedback. When sexual attractions manifest themselves with certain patients, transfer those patients to the care of another physician and seek counseling. Never act on the attraction as a means of resolving the feelings of sexual attraction.

2. Be alert for, and maintain boundaries with, patients who may encourage a sexual relationship. (Then, follow 1 above.)

3. Respect a patient's dignity at all times, and provide appropriate gowns and private facilities for dressing, undressing, and examination. Avoid being present in the room when a patient is dressing or undressing.


4. Have a chaperon present during patient examinations involving sensitive body parts. Do not conduct such an examination if the patient sexualizes the examination (or appears to).

5. To minimize misunderstanding or misperceptions, always explain the need for each examination, test, or procedure component.

6. Choose words carefully so that communications are clear, appropriate, and professional.

7. Seek information and education about sexual misconduct, and educate other health care providers and students.

8. Never discuss your own intimate personal problems/lives with patients.



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Original Contribution

Comparison of Female and Male Graduates of Southern Appalachian Family Practice Residencies

Jo Ann Rosenfeld, MD; P.M. Zaborlik, PhD

Introduction

One of the purposes of family practice residency programs, especially those in or near rural and underserved areas, has been to provide graduates who will practice in surrounding physician-sparse areas. Southern Appalachia has been such an area. There has been some evidence that female graduates are less likely to practice in rural areas and small towns,¹ less likely to practice full-time, and less likely to give prenatal or delivery care.²⁻⁴ If this is true, the increasing number and percentage of women among family practice residency graduates may

affect the yield of small town and rural physicians. The Southern Highlands Appalachian Research Project (SHARP), a group of family practice residency faculty from five states (Kentucky, Tennessee, North Carolina, Virginia, and West Virginia) and nine residency programs* surveyed physicians who completed their residencies between 1984 and 1994 to determine graduates' practice locations and characteristics, and reasons for the choice of location. The purpose of this was to determine if the residencies are producing family physicians for rural Appalachia, and if the female graduates are fulfilling the aims of these residencies as well as the men.

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ABSTRACT

Purpose: One aim of Southern Appalachian family practice residencies is to produce graduates for surrounding physician-needy areas. Some evidence suggests that women are less likely to go to rural areas and that they practice differently than men. This study investigated the practice patterns and location of Appalachian family practice residency female and male graduates.

Methods: Surveys were sent to graduates of seven family practice residencies from 1984 to 1994 in the Southern Appalachian area to determine practice patterns, locations, and reasons for choosing practices.

Results: Women were more likely than men to be single and not to have children. More women worked part-time. Women's and men's practice patterns and characteristics were similar except that women were more likely to provide prenatal care and do vaginal deliveries. Women in similar percentages practiced in small towns, and a greater percentage of women practiced in rural areas with populations of less than 2,500.

Conclusions: Female family practice residency graduates from Appalachian residencies are fulfilling the purposes of their residencies as well as male graduates, although more of them are working part-time.

Methods

A survey instrument was developed through a group process over a period of one year by SHARP members. The survey included items pertaining to demographics, education locations, selection of residency program, selection of current practice location, and practice characteristics.

Surveys were sent to 640 graduates of six residencies during 1984-1994. Addresses were supplied by the individual residency programs. Addresses of nonrespondents were verified through the American Academy of Family Physicians (AAFP) and through directory information

in each state. A reminder card, a second mailing, and finally an attempt to contact a limited number of nonrespondents by phone resulted in a total return of 347 surveys (54%). For 73 individuals (11.2%), there was documentation of non-delivery or disconnected phone. The return rate was then adjusted to 60.8%. Data were analyzed using the Statistical Package for the Social Services correlation.

*Faculty were from the following residencies: Hazard Family Practice, Hazard, KY(1); Bristol, Kingsport and Johnson City Family Practice Residencies of East Tennessee State University; University of Tennessee Knoxville Family Practice Residency, Knoxville; MAHEC, Asheville, NC; Roanoke Family Practice Residency, Roanoke, VA; West Virginia College of Osteopathic Medicine Family Practice Residency, Lewisburg WV(1); West Virginia University Family Practice Residency—all these participated in SHARP. However those with (1) had no residency graduates during 1984-1994.

Results

There were 347 responses. Although women made up only 20% of the total graduates, 22.5% of the respondents were women; more women (78/130; 60%) than men responded (269/520; 51%). Three percent of women and men were non-white. There were some significant differences in demographic data. Women were less likely to be married and have children (Table 1). The areas of practice were identical, 69% of both men and women practicing in the five-state area (TN-VA-WV-KY-NC).

Most practice patterns of the graduates were similar. Similar percentages of women and men were in solo practice or in group practices with more than six physicians (Table 2). Over 70% of both men and women lived in the community in which they practice. Although less than one-third of both men and women described the size of their community, of those who did most were living in small towns. Almost half the women and over two-thirds of the men lived in towns of less than 50,000. More women worked in areas that were more rural and had fewer physicians. Significantly more women than men were working in communities of less than 2,500 population (35% vs. 24%) and in communities that had fewer than 30 physicians (53% vs. 40%).

There were some practice differences. Women were more likely to work part-time (Table 2), and to plan to stay in their present practice situation less than five years. More married women (15/51; 29%) than single women (5/27; 18.5%) worked part-time.

The characteristics of the physicians' practices were fairly similar. Women were as likely as men to work in emergency situations and saw similar percentages of adults, elderly, and children in their practice. Women saw slightly more adolescents (43% of women said they saw over 10% adolescents compared to only 25% of men) and were significantly more likely to practice prenatal care, perform vaginal deliveries, and assist at cesarean sections (Table 3). Although a few men did cesarean sections, no women did. The percentages of men and women who had hospital privileges in family practice, pediatrics, psychiatry, ICUs, and surgery were similar.

TABLE 1

DEMOGRAPHIC DATA ON FEMALE AND MALE GRADUATES

	Women number (%)	Men number (%)
Married*		
Yes	51 (66.3)	244 (81)
No	27 (23.7)	25 (9)
Have children*		
Yes	50 (65)	225 (79.1)
No	28 (35)	43 (16.5)
Unknown	1 (0.4)	
Total	78	269

*P value ≤ 0.001

The surveys asked what lifestyle and practice factors contributed to the physicians' choice of practice location. The available choices are listed in Table 4. Women and men had similar reasons for choosing their location and practice except that more men considered sports and recreational opportunities and opportunities to establish on their own.

Discussion

There is maldistribution of physicians in the United States, and over 45 million Americans live in areas where health care is inadequate or nonexistent; there are at least 120 rural counties without a physician.⁵ One of the purposes of rural and small-town family practice residencies like those in SHARP is to produce physicians for these physician-needy areas.

There have been few studies comparing women and men's practices, and a few comparing rural and urban and intrastate and out-of-state graduates, but none comparing rural family practices of women and men. The few available either were Canadian or used different populations of graduates.

Several studies showed more women than men practicing part-time.^{2,3,4,6} Female family practice physicians saw fewer patients, were less likely to be in solo practice,⁷ and were less likely to practice obstetrics.⁴ Female physicians were less likely to practice in rural areas.^{1,8,9} There have been concerns that these differences might affect how the family practice residencies fulfill their purposes.⁸ If women are less likely to work rural areas, would this affect physician distribution? One review of all U.S. physicians suggested that although women are more likely to practice part-time and retire younger, their longer life balanced the work of male physicians.⁶

Female graduates in Southern Appalachia are practicing in rural areas in the five-state areas similar to the male graduates and in similar ways. There were a few differences, most of them predictable.

The residency graduates of the Southern Appalachian resi-

TABLE 2

PRACTICE PATTERNS OF FEMALE AND MALE GRADUATES

	Women number (%)	Men number (%)
Practicing		
Full-time	58 (73)	261 (97)
Part-time*	20 (27)	6 (1.7)
Not practicing	0	2 (0.3)
Number other physicians in practice		
Solo	13 (19)	52 (18)
2 to 5	30 (38)	79 (31)
6 or more	26 (31)	118 (45)
Unknown	8 (12)	19 (6)
Time plans to be in present practice		
Less than 5 years*	19 (26)	50 (18)
5 to 10 years	19 (26)	38 (14)
More than 10 years	36 (43)	172 (65)
Unknown	4 (6)	8 (3)

*P value < 0.001

TABLE 3

PERCENT OF PHYSICIANS WITH HOSPITAL PRIVILEGES AND OBSTETRICAL PRACTICE

	Women	Men
Obstetrics Privileges	21	14
Prenatal care*	28	15
Vaginal delivery†	20	10
Assist at cesarean section†	15	7
Primary cesarean section	0	2
Family Practice	79	81
Pediatrics	54	52
Psychiatry	14	15
Surgery	5	6
ICUs	51	54

*P value <0.01; †P value <0.05; The other differences were not significant.

dependencies surveyed were representative of family practice graduates and active members of the AAFP. According to the AAFP 1994 yearly survey,¹⁰ in 1994, approximately 18.4% of active members were women; 22.5% of responders of this survey were women, comparing well with these national numbers, since in 1984, 20.6% of graduates were women, in 1993, 34.8%.

This survey had only a 60.8% actual response rate. This may cast into doubt some of its findings. However, surveys of practicing physicians infrequently have higher response rates. The graduates of the programs had graduated over a ten-year period. Some of the residencies were fair and some were poor in keeping records of their early graduates' addresses. Although the names were rechecked with records from the AAFP, some physicians do not belong to this organization. Residencies typically graduate only 6 to 12 residents a year. Even over a ten-year period in one residency, only approximately 60 to 120 residents in one program could be surveyed. This survey is unique and important because it has canvassed such a large number of residents, in a specific geographic and cultural area that crosses state lines, and resident graduates who attended residencies with similar philosophical missions—to produce rural physicians.

Female family physicians were less likely to be married and have children, as are other younger female physicians, though this may be a function of the survey tool. Married women, especially those with children, may be busier and less likely to respond to surveys. Women were as likely as men to be in solo or large group practices, and more likely to live in very rural areas and in areas with few physicians. Women seem to be choosing rural and physician-needy areas to practice. However, women were more likely to practice part-time. Predictably, more married than single women (all of whom except one have children) work part-time.

Except for obstetrical privileges, the characteristics of women's practices were very similar to men's, in both the office and the hospital. Unlike in Canadian studies,⁴ women were much more likely to practice prenatal care and do vaginal deliveries. Twenty percent of female family residency

TABLE 4

REASONS FOR CHOOSING PRACTICE LOCATION*

	Women	Men
Family Reasons		
Hometown	16	16
Spouse's hometown	12	17
Near own family	39	40
Near spouse's family	28	20
Good schools	33	32
Good community to raise children	60	50
Cultural opportunities	39	36
Sports/recreation opportunity†	40	53
Rural atmosphere	57	56
Climate/geography	72	60
Practice Considerations		
Doctors respected	51	40
Opportunity for comprehensive care	54	54
Not high-tech	34	32
Opportunity to practice with known physicians	29	33
Opportunity to establish own practice‡	40	23
Obligation	10	8
Adequate time off	51	52

*Physicians could check as many answers as they wanted. Listed is the percent of physicians who checked that factor.

†P <0.05; ‡P <0.01; The other differences were not significant.

graduates and 10% of male graduates did vaginal deliveries. More of the women delivered babies than the 9.9% to 16% of total AAFP members in the Southeast who did.

Except for sports opportunities, the reasons women chose their practice sites were very similar to those of the men. Although similar numbers of women and men were in solo practice, more men chose this as one of their reasons for choosing a particular type practice.

Female family practice residency graduates are fulfilling the purpose of their residency programs to produce physicians for rural and needy areas. Although more are practicing part-time, more women than men are practicing in small towns and rural areas, and are practicing obstetrics, an area of medicine in which access has been especially difficult in rural areas. Practice choices and patterns are otherwise similar, and residencies and communities should use these findings to continue to encourage women to choose family practice in rural areas. □

References

1. Kassebaum DG, Szenas PL: Rural sources of medical students and graduates' choice of rural practice. *Academic Med* 68:232-236, 1993.
2. Ward S: Kansas women physicians respond to survey. *Kansas Med* 94:224-227, 1993.
3. Hojat M, Moses S, Gonnella JS, et al: Comparisons of male and female physicians on their practice patterns, professional activities and perception of professional problems. *Proc Ann Conf Res Med Educ* 26:23-27, 1987.
4. Norton PG, Dunn EV, Soberman L: Family practice in Ontario. *Can Fam Phys* 40:249-256, 1994.
5. Geyman JP, Ciriacy EW, Mayo F, et al: Geographical distribution of family practice graduates: the experience of three statewide networks. *J Fam Pract* 11:761-766, 1980.
6. Kleitke PR, Marder WD, Silberger AB: The growing proportion of female physicians: implications for US physician supply. *Am J Pub Health* 80:300-304, 1990.
7. Wakeford RE, Warren VJ: Women doctors' career choice and commitment to medicine: implications for general practice. *Can Med Assoc J* 143:194-201, 1990.
8. Bowman MA: Women physicians: facts, fantasies, and prospects. *J Med Pract Management* 2:130-134, 1986.
9. Bowman M, Gross ML: Overview of research on women in medicine—issues for public policymakers. *Public Health Rep* 101:513-521, 1986.
10. FACTS about family practice-1994. American Academy of Family Physicians Yearly Survey, Kansas City, MO, 1994.

Stroke Prevention Series

Medical Revolution: The Prevention and Treatment of Stroke, 1996

Part 2. Medical Prevention of Stroke and Acute Stroke Therapy

Howard S. Kirshner, MD

Antiplatelet Agents in Thrombotic Stroke

Two medications, aspirin and ticlopidine, have been shown to prevent stroke by inhibiting platelets. Several large, randomized trials have supported the use of aspirin to prevent stroke. The Canadian study¹ documented a nearly 50% reduction of stroke and/or death in men with TIA treated with 1,200 mg of aspirin per day; women showed no benefit. Controversy persists regarding the optimal dose of aspirin. Small doses (80 mg/day or less) have been advocated on the theoretical grounds that low-dose aspirin inhibits the platelet for its lifetime, but the production of prostacyclin, a platelet inhibitor, by the vessel wall is only temporarily disrupted. A British study found no difference in effectiveness between 325 and 1,200 mg of aspirin per day.² Other studies have shown some benefit even with smaller doses of aspirin, but none has compared two doses of aspirin against a placebo. Currently, aspirin is approved by the FDA for stroke prevention in men with TIA at a dose of 1,200 mg/day. Many clinicians use lower doses of 80 to 325 mg/day. In the future, qualitative platelet measurements may become standard practice to determine the optimal dose of aspirin for each patient.

Ticlopidine, a newer antiplatelet drug that blocks ADP-dependent platelet aggregation, has shown benefit in two major studies. In the TASS study of TIA or mild stroke,³ ticlopidine reduced the rate of stroke by 21% compared to aspirin at the end of three years. The absolute stroke prevention was 3%, or 1% per year. Further subgroup analysis of the TASS data has shown that the relative stroke reduction was 47% during the first year, less in subsequent years, and that ticlopidine is superior to aspirin in both men and women, in patients with both vertebrobasilar and carotid TIA or stroke,

in both blacks and whites, and in both diabetics and non-diabetics. In the Canadian American Ticlopidine Study (CATS)⁴ of patients with completed strokes, ticlopidine prevented recurrent stroke by 33% more than placebo. Ticlopidine has a higher incidence of side effects than aspirin, particularly diarrhea, rash, and occasional neutropenia. The recommended dose is 250 mg twice a day, with a CBC every two weeks for the first 90 days of treatment. The FDA considers ticlopidine the first line treatment for stroke prevention in women with TIA and in both sexes with completed stroke.

Current stroke prevention trials include a new ticlopidine-like drug, clopidigil, which reportedly does not suppress the bone marrow. A multicenter study of aspirin versus warfarin (WARSS) in ischemic strokes unassociated with either significant carotid stenosis or a definite cardiac source of embolus is also underway.

Patients with stroke or TIA secondary to a surgically inaccessible stenosis in the basilar, intracranial internal carotid, or proximal middle cerebral arteries are often treated with antiplatelet agents, with anticoagulation for refractory patients. A trial comparing aspirin and warfarin in these patients is planned. The superficial temporal-middle cerebral bypass operation did not prove effective and has been largely abandoned. Interventional radiological procedures such as balloon angioplasty hold future promise.

Prevention of Cerebral Emboli

Of the many causes of embolic stroke, atrial fibrillation (AF) is the most common and the best studied. The transesophageal echocardiogram has improved detection of embolic sources from 15% to over 50%, and correspondingly the percentage of strokes that are cardioembolic is likely to increase from approximately 15% to 30%. The prevention of embolic stroke involves anticoagulation with heparin or warfarin. Five large, randomized series have all confirmed the benefit of warfarin in primary stroke prevention in patients with AF⁵⁻⁹ (Table 1). About three strokes can be prevented per 100 patients treated with warfarin per year. Two

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TABLE 1
RANDOMIZED STUDIES OF STROKE PREVENTION IN
ATRIAL FIBRILLATION WITH WARFARIN

Study	AFASAK	SPAF	BAATAF	CAFA	SPINAF
% decrease	58%	67%	86%	42%	79%
INR range	2.8-4.2	2.0-4.5	1.5-2.7	2.0-3.0	1.4-2.8
% bleeding	0.8%	1.6%	1.2%	2.1%	1.2%

of the five studies also evaluated aspirin: the Danish study found no benefit, while the Stroke Prevention in Atrial Fibrillation (SPAF) study found a lesser benefit with aspirin than with warfarin. The VA (SPINAF) and Boston (BAATAF) trials indicated that warfarin is effective in preventing stroke at low levels of anticoagulation (INR 1.5-3).

In secondary stroke prevention, the European trial¹⁰ of patients with nonvalvular AF and prior stroke or TIA reported a 66% reduction in the incidence of stroke with warfarin, from 12% to 4%, which amounts to prevention of nine strokes per 100 patients per year. In the same trial, aspirin reduced strokes from 12% to 10% per year, a prevention of four strokes per 100 patients per year. Warfarin is thus more effective in preventing strokes in those with previous stroke or TIA than in asymptomatic AF patients.

Controversy continues regarding the immediate anticoagulation of patients with embolic stroke. Patients with acute stroke and AF or recent MI have a high risk of recurrence, but early anticoagulation may transform a bland infarct into a hemorrhagic infarct or hematoma. Some experts recommend a delay of three days in anticoagulation of patients with large infarctions, while others favor immediate anticoagulation.

Acute Management of Stroke

Until now, the treatment of stroke has been supportive: bedrest, turning, range of motion, monitoring of swallowing to avoid aspiration pneumonia, subcutaneous heparin or compression stockings to deter pulmonary embolism, and rehabilitative therapies. Steroids are ineffective in treating edema in acute stroke, and may worsen outcome. Osmotic agents are used only to prevent impending cerebral herniation. The acute use of heparin in progressing or waxing-waning stroke is controversial, with little randomized data to support its use. Current trials of low molecular weight heparin may provide better evidence of benefit.

A number of experimental stroke therapies are currently being evaluated. Thrombolytic agents have the promise of lysing a clot before irreversible tissue damage has occurred. This intervention must be carried out soon after onset, because later thrombolysis will not affect tissue damage and may cause hemorrhage. Recently, the FDA has approved intravenous tissue-type plasminogen activator (tPA) for use in

ischemic stroke within three hours after onset, officially opening the era of acute therapeutic intervention in stroke. The NIH trial,¹¹ with a time window of 180 minutes after first symptoms, showed benefit at three months; 30% more tPA-treated than placebo-treated patients had mild or no disability. The risk of bleeding was tenfold increased (6.4% vs 0.6%), but overall mortality was similar in the two groups. Perhaps surprisingly, patients with embolic, large vessel-thrombotic, and small vessel-thrombotic strokes all showed benefit. An earlier, European trial with a six-hour window was less definitive, indicating less stroke deficit but higher mortality and bleeding rates in treated patients. A large North American trial of tPA with a three- to five-hour treatment window is soon to begin. Current FDA recommendations for use of tPA are shown in Table 2.

In addition to tPA, streptokinase, urokinase, and anicrod are being investigated for thrombolytic effects in acute stroke. Intravenous streptokinase has been tested in Europe, with little indication of benefit and increased risk of hemorrhage. Anicrod, a fibrinogenolytic agent derived from the venom of the Malayan pit viper, has secondary thrombolytic activity but may have a lower risk of bleeding as compared to other thrombolytic agents. A multicenter trial is in progress. Intra-arterial thrombolysis with streptokinase or urokinase has shown impressive results in recanalization of vessels and good outcomes in small series of patients. The intra-arterial approach requires a cerebral arteriogram prior to infusion of the drug, thereby imposing a delay and restricting treatment to major centers. The advantage of direct visualization of the occluded vessel and detection of recanalization makes the procedure popular among interventional neuroradiologists, but larger studies are needed.

TABLE 2
CLINICAL GUIDELINES FOR USE OF tPA IN ACUTE STROKE

1. Treatment within three hours of stroke onset (or last observed period of normalcy)
2. CT scan to exclude hemorrhage, infarction or mass effect, or intracranial mass
3. Criteria for patient exclusion include
 - a. Mild or rapidly improving deficits
 - b. Severe deficits such as obtundation, fixed eye deviation, or complete hemiplegia
 - c. Recent (three months) stroke, head injury, or intracranial surgery
 - d. Suspected subarachnoid hemorrhage
 - e. Any history of intracranial hemorrhage
 - f. BP >185 mm Hg systolic or >110 mm Hg diastolic at time of treatment
 - g. Seizure at or after stroke onset
 - h. Any active internal bleeding
 - i. Known AVM, aneurysm, or intracranial neoplasm
 - j. Any known bleeding diathesis, including use of warfarin with PT >15 sec, heparin within 48 hours or APTT elevated, platelet count <100,000
4. The dose of tPA is 0.9 mg/kg, infused IV, with 10% as an initial bolus and the remaining 90% infused over one hour. The maximum dose is 90 mg
5. The patient should be closely monitored for intracerebral hemorrhage at a center with neurosurgical capability

Experimental "neuroprotective" therapies have sought to exploit new knowledge about the pathogenesis of ischemic cell damage. Stroke has traditionally been assumed to result from depletion of energy supplies, leading to membrane depolarization and cell death. Recent studies, however, have shown that damage occurs in the "ischemic penumbra" before ATP stores are depleted. Cell necrosis leads to release of excitatory transmitters such as glutamate, calcium ions, and free radicals, all of which lead to a cascade of cell damage. The calcium channel blocker nimodipine, approved for prevention of delayed ischemic damage after subarachnoid hemorrhage, has had mixed results in stroke. Further study of this drug, with a shorter "window," appears warranted. Experimental blockers of the n-methyl-d-aspartate (NMDA) subtype of glutamate receptor are being tested in stroke, but have the potential to cause hallucinations and confusion. The new antioxidant drug tirilizad, a "lazaroid" or 21-amino-steroid, is also in testing.

In the future, a strategic, early intervention-based approach to stroke is contemplated in which the public will be educated to call 911 immediately after a patient develops a "brain attack" (stroke), and emergency medical technicians will

administer neuroprotective drugs such as nimodipine, free radical scavengers, and NMDA-receptor blocking drugs. The patient will then be transported to a medical facility for brain imaging and consideration of thrombolytic therapy. A greater number of stroke patients may thus recover full function. □

References*

1. Canadian Cooperative Study Group. A randomized trial of aspirin and sulfinpyrazone in threatened stroke. *N Engl J Med* 299:53-59, 1978.
2. UK-TIA Study Group: The United Kingdom transient ischaemic attack (UK-TIA) aspirin trial: final results. *J Neurol Neurosurg Psychiatry* 54:1044-1054, 1991.
3. Haas W, Easton JD, Adams HP Jr, et al: A randomized trial comparing ticlopidine hydrochloride with aspirin for the prevention of stroke in high-risk patients. *N Engl J Med* 321:501-507, 1989.
4. Gent M, et al: The Canadian American Ticlopidine Study (CATS) in thromboembolic stroke. *Lancet* 1:1215-1220, 1989.
5. Petersen P, Boysen G, Godtfredsen J, et al: Placebo-controlled, randomised trial of warfarin and aspirin for prevention of thromboembolic complications in chronic atrial fibrillation: the Copenhagen AFASAK Study. *Lancet* 1:175-179, 1989.
6. Stroke Prevention in Atrial Fibrillation Study Group Investigators: Preliminary report of the Stroke Prevention in Atrial Fibrillation Study. *N Engl J Med* 322:863-868, 1990. Final report *Circulation* 84:527-539, 1991.
7. The Boston Area Anticoagulation Trial for Atrial Fibrillation Investigators: The effect of low-dose warfarin on the risk of stroke in patients with nonrheumatic atrial fibrillation. *N Engl J Med* 322:1505-1511, 1990.
8. Connolly SJ, Laupacis A, Gent M, et al: Canadian Atrial Fibrillation Anticoagulation (CAFA) Study. *J Am Coll Cardiol* 18:349-365, 1991.
9. Ezekowitz MD, Bridgers SL, James KE, et al: Warfarin in the prevention of stroke associated with nonrheumatic atrial fibrillation. *N Engl J Med* 327:1406-1412, 1992.
10. European Atrial Fibrillation Trial Study Group. Secondary prevention in nonrheumatic atrial fibrillation after transient ischaemic attack or minor stroke. *Lancet* 342:1255-1262, 1993.
11. The NINDS rt-PA Stroke Study Group. Tissue plasminogen activator for acute ischemic stroke. *N Engl J Med* 333:1581-1587, 1995.

*Note: A more complete version of this article, with complete references, is available from the author.

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Trauma Rounds

Nonoperative Management of a Blunt Pancreatic Injury

John R. Hall, MD; Paul Crawford, MD; James V. Lewis, MD

Introduction

Pancreatic injury due to blunt trauma is fairly rare due to the deep retroperitoneal location of the pancreas. Its incidence is reported in less than 2% of patients with blunt trauma, but it may occur in up to 10% of those with severe abdominal trauma.^{1,2} The deep location makes it difficult to diagnose these injuries, and thus the diagnosis is often delayed.

The majority of the trauma literature discusses the acute operative management of pancreatic injuries. This is a case report of blunt pancreatic injury managed nonoperatively. We present a summary of the patient's clinical course and a brief discussion.

Case Report

A 24-year-old woman, who was the unrestrained driver of a car that hit a stopped vehicle, was thrown against the dashboard and steering wheel. Because of a questionable loss of consciousness the patient was admitted for neurologic observation. The initial and subsequent abdominal examinations were unremarkable, and a routine serum amylase done at that time was 151 U/L (normal 37 to 177). She was discharged two days later.

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Seven days later she came to the emergency room complaining of right upper quadrant and epigastric pain, anorexia, and occasional nausea and vomiting. A serum amylase at that time was 408 U/L. The patient was afebrile and did not appear particularly ill but did have a palpable, tender right upper quadrant abdominal mass. A CT scan of the abdomen (Fig. 1) showed a large pancreatic phlegmon.

The patient was treated in the hospital with bowel rest and intravenous parenteral nutrition. Octreotide and kenovac, a cholecystokinin analog, were added to the treatment regimen. The patient also had back pain that required analgesics. Her serum amylases remained mildly elevated. A repeat abdominal CT scan done eight days later showed partial resolution of the pancreatic phlegmon and the development of a pseudocyst (Fig. 2).

After several days she was allowed a fat-free diet, which did not increase either her pain or her serum amylase. She remained afebrile and without significant abdominal tenderness, and because of the improvement in the CT findings and in her clinical condition she was discharged on the 14th hospital day to continue on her fat-free diet.

Over the next three weeks she became asymptomatic and was able to resume a regular diet. A repeat CT scan (Fig. 3) showed almost complete resolution of the pancreatic pseudocyst. She has since returned to work and remains symptom-free.

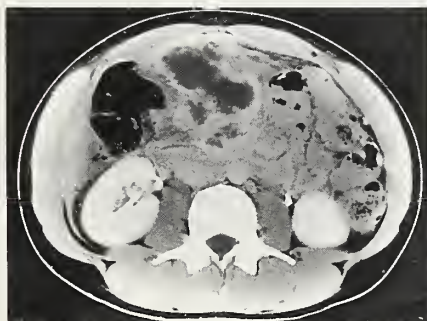


Figure 1. Admission CT scan of the abdomen showing a large pancreatic phlegmon.

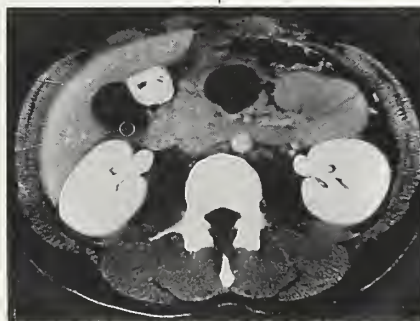


Figure 2. CT scan of the abdomen done eight days after admission showing partial resolution of the pancreatic phlegmon and development of a pseudocyst.

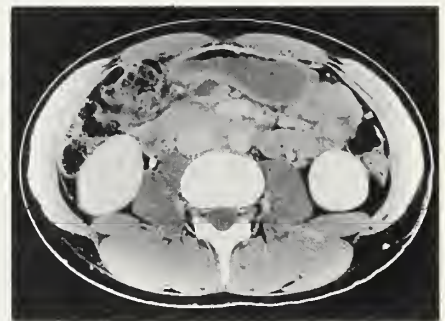


Figure 3. Follow-up CT scan of the abdomen done six weeks post-injury showing almost complete resolution of the pancreatic pseudocyst.

Discussion

Blunt pancreatic injuries occur when a high-energy force is applied to the upper abdomen, compressing the pancreas between the external agent and the spine. In the adult literature, the majority of these injuries result from motor vehicle accidents, with 60% of these due to impact with the steering wheel²; in children, the predominant mechanism is a handlebar injury. Associated extra-abdominal injuries are reported in 94% of these patients, and 85% have associated intra-abdominal injuries.³ Other reviews have found isolated pancreatic injuries in as many as 33% of patients.⁴ As in this patient, there is often no initial clinical evidence of a pancreatic injury. In one study, only 8% of patients with hyperamylasemia had confirmed pancreatic injury, whereas 33% of patients with hyperamylasemia had significant, non-pancreatic intra-abdominal injury.⁵ In the multicenter study done by the Western Trauma Association, only 50% of patients with blunt pancreatic injury had elevated amylases,³ but prolonged elevation or a progressively rising serum amylase is highly suggestive, and an elevation of longer than six days following injury is virtually diagnostic of pancreatic injury.⁴ Continued abdominal pain, vomiting, fever, and an abdominal mass following trauma are clinical signs suggestive of a pancreatic injury, and work-up should then include a CT or abdominal ultrasound.

The management of pancreatic injuries traditionally has been operative, with the type of procedure—primarily repair and external drainage or resection—depending upon whether the pancreas is injured proximally or distally, and on whether or not the duct is disrupted.

Pediatric trauma surgeons have led in the “conservative” nonoperative management of abdominal trauma, and it is therefore not surprising that they were the first to propose the nonoperative management of pancreatic injuries.⁶⁻⁸ As in the management of liver and spleen injuries, nonoperative management is dictated by the patient’s clinical course and not by the injury classification. Transection of the pancreas as documented by CT or ultrasound is an obvious indication for operative intervention.

Treatment of pancreatic injuries involves putting the pancreas “at rest” by giving the patients nothing by mouth and preferably starting enteral or parenteral alimentation. Antibiotics are not given other than as an initial prophylactic measure. The indications for drainage of post-traumatic pancreatic pseudocysts are infection or rupture of the cyst and failure of conservative management.

There are three specific complications of pancreatic injury, which are usually the result of leakage of exocrine secretions: pseudocyst formation, fistulas, and abscesses. It has been suggested that pseudocyst formation complicates 33%

to 45% of pancreatic injuries.^{4,9} There also appears to be no difference in the incidence of pseudocyst formation in patients operated on or those followed nonoperatively.¹⁰ Pseudocyst formation occurs when leaking pancreatic fluid is encapsulated within a fibrinous exudate, usually in the lesser sac. Not all pancreatic phlegmon will progress to true cyst formation. Traumatic pseudocysts differ from those due to acute or chronic pancreatitis in that the pancreatic parenchyma and duct are usually normal; thus, spontaneous resolution is usually the rule, with about half resolving with medical therapy alone.⁹ Observation is recommended for a minimum of six to eight weeks. Cysts that fail to resolve by this time are candidates for drainage. Unlike the pseudocysts of chronic pancreatitis, up to 90% of traumatic pseudocysts respond to radiologic percutaneous external drainage.¹¹

The use of octreotide, an 8-amino acid synthetic analogue of the inhibitory peptide somatostatin, may help in the prevention of pancreatic fistula and speed spontaneous resolution of pseudocysts. It decreases both pancreatic secretory volume and enzyme production. As pseudocyst formation is due to either microscopic or macroscopic ductal disruption with subsequent leakage of pancreatic juices, it seems logical that control of these secretions could control the growth of the pseudocyst and allow ductal healing. Gallo and Barbara¹² found that 0.1 mg octreotide SQ three times daily for two weeks decreased the size of pseudocysts from all causes in four of seven patients.¹² A recent randomized trial also demonstrated a beneficial effect in the treatment of severe acute pancreatitis.¹³

Nonoperative treatment of liver, spleen, and kidney injuries is now becoming the norm of trauma management. Blunt pancreatic trauma in the absence of glandular transection or other injuries requiring operative intervention may also be best treated nonoperatively. □

References

1. Weisner DH, Wold RL, Frey CF: Diagnosis and treatment of pancreatic injuries. *Arch Surg* 125:1109-1113, 1990.
2. Jurkovich GJ: Injury to the duodenum and pancreas, in Feliciano DV, Moore EE, Mattox KL (eds): *Trauma*, ed 3. Stamford, CT, Appleton and Lange, 1996, pp 573-594.
3. Cogbill TH, Moore EE, Morris JA Jr, et al: Distal pancreatectomy for trauma: a multicenter experience. *J Trauma* 31:1600-1606, 1991.
4. Northrup WF III, Simmons RL: Pancreatic trauma: a review. *Surgery* 71:27-43, 1971.
5. Olsen WR: The serum amylase in blunt abdominal trauma. *J Trauma* 13:200-203, 1973.
6. Gorenstein A, O'Halpin D, Wesson DE, et al: Blunt injury to the pancreas in children: selective management based on ultrasound. *J Pediatr Surg* 22:1110-1116, 1987.
7. Othersen HB Jr, Moore FT, Boles ET: Traumatic pancreatitis and pseudocysts in children. *J Trauma* 8:535-546, 1968.
8. Bass J, DiLoren M, Desjardins J, et al: Blunt pancreatic injuries in children: the role of percutaneous external drainage in the treatment of pancreatic pseudocysts. *J Pediatr Surg* 23:721-724, 1988.
9. Burnwall C, Wesson D, Stringer D, et al: Percutaneous drainage of traumatic pancreatic pseudocysts in children. *J Trauma* 30:1273-1277, 1990.
10. Lewis G, Krige JEJ, Bornman PC, et al: Traumatic pancreatic pseudocysts. *Br J Surg* 80:89-93, 1993.
11. Grace PA, Williamson RCN: Modern management of pancreatic pseudocysts. *Br J Surg* 80:574-581, 1993.
12. Gallo L, Barbara L: Treatment of pancreatic pseudocysts with octreotide. *The Lancet* 338:540-541, 1991.
13. Paron H, Neufeld D, et al: Preliminary report of a prospective randomized study of octreotide in the treatment of severe acute pancreatitis. *J Am Coll Surg* 181:121-124, 1995.

Department of Health Report

Preventing Childhood Lead Poisoning in Tennessee

Mary Yarbrough, MD, MPH; Marilyn Holmes, MS, RD, LDN

Children are at risk for lead poisoning, which can result in developmental delays, deficits in intellectual performance and neurobehavioral functioning, decreased stature, and diminished hearing acuity.¹ Most recently, studies have linked lead exposure with increased risk for antisocial and delinquent behavior.² In children 1 to 5 years of age, 8.9% have blood lead levels (BLLs) of ≥ 10 $\mu\text{g/dl}$, levels that are of concern to a developing child's good health.³ Public health efforts in the last 20 years have made great progress in lowering the blood levels of lead in the U.S. population from an overall mean of 12.8 $\mu\text{g/dl}$ in the National Health and Nutrition Examinations Survey II (1976-1980) (NHANES) to 2.8 $\mu\text{g/dl}$ in NHANES III (1988-1991). Still, children, especially those from minority, urban, and low-income families, as well as all children living in homes built prior to 1978, are at risk. Efforts for the identification and treatment of lead poisoning in children have been underway in the state of Tennessee for two decades. In the past five years, a statewide program, made possible through a grant from the Centers for Disease Control and Prevention (CDC), has made it possible to enhance screening programs in all 95 counties. In half of the metropolitan and half of the rural regions, model programs have been implemented.

The Tennessee Childhood Lead Poisoning Prevention Program has nine components:

Screening: Screening in Tennessee's health departments follows the CDC guidelines.⁴ Screening begins at 6 months and continues to 72 months.

Identification of Sources of Exposure: All children with BLLs ≥ 20 $\mu\text{g/dl}$, and some children with persistent BLLs of 15 to 19 $\mu\text{g/dl}$, require home investigation. Staff performing home investigations do so under a protocol, the basics of which include screening for lead in paint, soil, and other hazards such as batteries, lead sinkers, pottery, parental occupa-

tions and hobbies, and home remedies. X-ray fluorescence instrumentation is used to screen for lead in the paint.

Medical Management: All children with a BLL of 15 to 19 $\mu\text{g/dl}$ documented twice in three months, or a BLL of ≥ 20 $\mu\text{g/dl}$ on first screening, are referred to a physician for examination and treatment. The first line of treatment is to identify and remove the child from the source of lead. CDC guidelines outline further medical management depending on the BLL. Current practice is guiding physicians away from chelation therapy when the BLL is < 45 $\mu\text{g/dl}$, as the benefit of such treatment has not been established.⁵ When chelation is necessary, oral agents, such as succimer (DMSA) or d-penicillamine, are now available to treat BLLs of < 70 $\mu\text{g/dl}$. Parenteral treatment with edetate disodium calcium (EDTA) and dimercaprol (BAL) should be used at higher levels.

Laboratory Support: Venipuncture is the preferred method for collecting blood for lead analysis. Electrochemical techniques are available to measure blood lead at levels below 25 $\mu\text{g/dl}$. Anodic stripping voltammetry and atomic absorption spectroscopy are two such techniques. Given analytical variability, differences in successive blood lead measurements are not considered significant unless there is a difference of ≥ 5 $\mu\text{g/dl}$ between samples.

Environmental Management: Since the 1970s, the use of lead in the environment has declined as the availability of leaded gasoline, lead soldered cans, and high content leaded paints has been reduced. As the consumption of these products has declined, mean BLLs in the population have declined. Today, the greatest source of lead poisoning in children is from structures covered in paint manufactured prior to 1978, the year lead content in household paints was reduced to its present low level of 0.06% lead by weight. Although abatement is costly, all efforts should be made to achieve this goal. When complete abatement is not possible, an acceptable alternative is to remove or encapsulate the lead painted structures. More information is available through local health departments, the Department of Environment and Conservation, or the National Safety Council (1-800-424-LEAD).

Public and Professional Information: The prevention of

From the Tennessee Department of Health, Nashville. Dr. Yarbrough is the former director of Environmental Epidemiology and Ms. Holmes is the Childhood Lead Poisoning Prevention Coordinator.

TABLE 1

TENNESSEE DEPARTMENT OF HEALTH CHILDHOOD LEAD POISONING PREVENTION PROGRAM SCREENING RESULTS

Model Regions	January - December, 1993					January - December, 1994					January - December, 1995				
	Total Screened	≥10*	% of Screens ≥10*	≥20*	% of Screens ≥20*	Total Screened	≥10*	% of Screens ≥10*	≥20*	% of Screens ≥20*	Total Screened	≥10*	% of Screens ≥10*	≥20*	% of Screens ≥20*
Metropolitan															
Memphis / Shelby County ¹	7,320	1,140	16	113	2	8,504	1,281	15	84	1	7,710	625	8	43	1
Chattanooga / Hamilton County ²	575	22	4	5	1	874	12	1	0	0	1,732	244	14	9	1
Jackson / Madison County ³	625	95	15	7	1	603	110	18	9	1	1,643	198	12	10	1
Rural															
Central Tennessee ²	3,802	385	10	28	1	2,610	256	10	22	1	5,764	197	3	4	<1
West Tennessee ¹	5,216	883	17	76	1	5,659	697	12	41	1	5,211	411	8	10	<1
Model Totals	17,538	2,525	14	229	1	18,250	2,356	13	156	1	22,060	1,675	8	76	<1
Non-Model Regions	January - December, 1993					January - December, 1994					January - December, 1995				
	Total Screened	≥10*	% of Screens ≥10*	≥20*	% of Screens ≥20*	Total Screened	≥10*	% of Screens ≥10*	≥20*	% of Screens ≥20*	Total Screened	≥10*	% of Screens ≥10*	≥20*	% of Screens ≥20*
Metropolitan															
Nashville / Davidson County	3,390	176	5	3	<1	1,600	71	4	3	<1	787	51	6	4	1
Knoxville / Knox County	519	63	12	1	<1	459	37	8	2	<1	522	51	10	6	1
Sullivan County	355	29	8	1	<1	271	17	6	0	0	130	4	3	0	0
Rural															
East Tennessee	5,442	421	8	34	1	2,993	273	9	18	1	1,864	214	11	24	1
Middle Tennessee	3,439	370	11	21	1	2,664	272	10	14	1	978	82	8	3	<1
Non-Model Totals	13,145	1,059	8	60	<1	7,987	670	8	37	<1	4,281	402	9	37	1
State Totals	30,683	3,584	12	289	1	26,237	3,026	12	193	1	26,341	2,077	8	113	<1

*All values are µg/dL BLL

¹Model Region since 1994²Model Region since 1995

lead poisoning in children requires the resources of many state agencies, including the Departments of Health, Environment and Conservation, Economic and Community Development, and Labor, as well as coordination and collaboration with health care providers and caretakers. Community coalitions of stakeholders have been formed in most of the state's major metropolitan regions to address problems and find solutions to lead poisoning.

Surveillance: To best utilize resources, efforts should be directed to those populations found to be at greatest risk. Since 1993, the state has collected information from the ten administrative regions for the Department of Health (Table 1). Statewide the number and percent of children with BLLs ≥10 µg/dl have decreased from 12% to 8%, which is below that of the national average of 8.9%. In general, metropolitan regions have higher percentages of children with BLLs ≥10 µg/dl than rural regions. Model regions screen more children because of enhanced screening activities in the health department population. As model regions enhance lead poisoning prevention activities, initial screening totals and percentages of elevated BLLs have been found to initially increase, then decline over time. This may be explained in part by increased detection and intervention, as well as improved record keeping aimed at avoiding duplication. Numbers of children screened have increased or remained stable in model

regions. In other regions, numbers have declined, most likely as a result of fewer children being served in health departments while screening activities have remained stable. Annually, more children enrolled in the TennCare Program are being seen by primary care providers. As is expected, many more children in all regions had BLLs in the 10 to 19 µg/dl range than in the ≥20. This difference may be explained in part as BLLs ≥20 µg/dl are confirmed on initial screen, whereas BLLs 10 to 19 µg/dl are not always confirmed on initial screen.

In Tennessee, sources of lead poisoning other than lead-based paint include parental occupations and hobbies, pottery, ceramic ware, and home remedies. By identifying those at greatest risk and the common sources of lead in poisoned children, the state has been able to target resources better.

Currently, state population-based prevalence rates for childhood lead poisoning are not complete. However, as the Department of Health's surveillance initiative is fully developed, a true assessment of the problem of lead poisoning will be possible. Complete surveillance data will allow better assessment of the problem, as well as information for program planning and identification of the highest risk areas of the state.

Evaluation: The Department of Health's Maternal and Child Health Section has primary responsibility for the Tennessee Childhood Lead Poisoning Prevention Program, which

(Continued on page 418)

Vanderbilt Morning Report

Progressive Somnolence and Confusion in a Patient With Hereditary Hemorrhagic Telangiectasias

Case Report

A 73-year-old woman with a history of hereditary hemorrhagic telangiectasias (HHT) characterized by recurrent epistaxis had a progressive decline in her mental status over a three-week period with increasing somnolence, ataxia, difficulty feeding herself, and urinary incontinence. Two days before admission she fell to the floor on two occasions. Her family did not recall that she had complained of any fevers, headaches, nausea, vomiting, focal weakness, visual or hearing changes, seizure activity, or access to any psychotropic medications. She had had laser ablation and numerous surgical packings for her epistaxis, and had required several transfusions of packed red blood cells. She also had chronic atrial fibrillation, a porcine aortic valve replacement in 1988 for a stenotic bicuspid aortic valve, and hypothyroidism.

On admission, she was somnolent but in no acute distress. Her temperature was 97.8°F, pulse 74/min, respirations 16/min, and blood pressure 130/74 mm Hg. She had an ecchymotic area over her right ear. The oral mucosa and many areas of the skin had multiple telangiectases that blanched on compression. Her neck was supple. Her chest was clear to auscultation although she made poor inspiratory effort. The cardiac examination showed an irregularly irregular rhythm and a grade 3/6 systolic murmur radiating to the carotids and left axilla. A pulsatile liver was percussed and palpated to 4 cm below the costal margin; no splenomegaly was noted. Cranial nerves were intact, pupils were equally round and reactive to light, and the fundi were sharp. The patient was unable to follow commands but withdrew all extremities to painful stimuli. Deep tendon reflexes were 3+ throughout; toes were down-going.

Laboratory tests showed a normal SMA-7, total protein 7.9 gm/dl, albumin 3.9 gm/dl, total bilirubin 1.9 mg/dl, alkaline phosphatase 125 U/L, total cholesterol 148 mg/dl, triglycerides 70 mg/dl, and LDH 351 mg/dl. A CBC revealed a WBC count of 4,700/cu mm, hematocrit 39%, and platelet

count 139,000/cu mm.

A chest x-ray showed evidence of prior cardiovascular surgery and aortic valve replacement. An EKG showed atrial fibrillation with a controlled rate. CT scan of the head without contrast showed no evidence of cerebral infarction or hemorrhage. A lumbar puncture revealed 1 white cell, 1 red cell, protein 48 mg/dl, and glucose 38 mg/dl. Gram stain and India ink stains were negative for organisms. MRI of the brain showed no abnormalities.

An electroencephalogram (EEG), recommended by the consulting neurologist to rule out seizure activity, showed an intermittent rhythmic discharge suggesting a nonconvulsive status epilepticus, and additional background 3 hertz spikes were typical of hepatic encephalopathy. A serum ammonia was markedly elevated at 140 µg/dl (normal 11 to 35). After the patient was given dilantin, continuous EEG monitoring showed resolution of the rhythmic discharges, and lactulose enemas produced progressive improvement of her mental status. She was discharged taking dilantin and lactulose. The patient had prior endoscopy that did not reveal esophageal varices, and had negative hepatitis serologies. She was admitted to the hospital on two other occasions for hepatic encephalopathy after episodes of noncompliance with the lactulose and increased protein intake.

Discussion

The term hereditary hemorrhagic telangiectasia was coined by Hanes in 1909. HHT, or Osler-Weber-Rendu disease, was first described by Rendu in 1896 as a distinct clinical entity. Osler and Weber subsequently described the syndrome in more detail further and identified it as a familial disease characterized by frequent hemorrhages. It is now known to be autosomal dominant with an estimated incidence of 1 to 2 per 100,000, although 20% of patients report no affected relatives.¹

Clinical signs of the disease usually appear in adolescence, and symptoms tend to increase in frequency and severity with age. Classically the disease is characterized by epistaxis and telangiectases. While the majority of patients have cutaneous or mucous membrane telangiectases, the systemic nature of this disease is demonstrated by the observation at autopsy

Presented by Taraz Samandari, MD, medical resident, and Brian D. Smith, MD, Hugh J. Morgan chief medical resident, Vanderbilt University Medical Center, Nashville

of these dysplastic vessels in every organ. The pathogenesis of the typical capillary-venous malformations is unknown.

The approach to a patient with HHT and mental status changes should be as with any individual with mental status changes, though certain distinct causes of neurologic disease are more commonly found in HHT. Neurologic complications are observed in 8% to 12% of members of families with HHT. In a review of 200 cases documented by angiography, surgery or autopsy, 61% of patients had neurologic sequelae secondary to pulmonary arteriovenous fistulas, with resultant cerebral hypoxemia, paradoxical emboli, septic emboli, or brain abscesses. Twenty eight percent of patients had vascular malformations of the brain, including cerebral arteriovenous malformations, telangiectasias, angiomas, and aneurysms. Six percent had portal-systemic encephalopathy.²

The patient presented herein had all the hallmarks of hepatic encephalopathy, probably resulting from portal systemic shunting. Other complications may include portal hypertension. Patients with shunts often show encephalopathy after significant gastrointestinal bleeding. In addition, hepatic encephalopathy may result from epistaxis and subsequent swallowing of blood—presumably due to products of digested protein.³ Physical examination of patients with portal-systemic shunts may demonstrate hepatomegaly, while a pulsatile mass, vascular thrill, or audible bruit may be noted in the upper abdomen. Asterixis and the musty odor of fetor hepaticus may be present on the patient's breath. Laboratory evaluation of liver function is usually normal. EEGs performed on patients with hepatic encephalopathy have frequently shown diffuse high-amplitude slow-frequency (theta) waves also described as bilateral synchronous triphasic waves.^{2,3}

Abdominal angiography is useful for diagnosing portal-systemic shunting, and may demonstrate dilatation and tortuosity of the hepatic artery, filling of numerous diffusely scattered intrahepatic pools, multiple angiomas and angiodysplasias, or early filling of hepatic veins.⁴ The liver of autopsied patients has been grossly described as pseudo-cirrhotic, with a diffusely nodular surface with multiple subcapsular hemangiomas.⁵ Histologically the hepatic lesion is usually described as periportal fibrovascular foci without major parenchymal or inflammatory reaction.

Patients with HHT may have a variety of liver abnormalities unrelated to, but superimposed on, the fibrovascular lesions: hepatic adenomas and focal nodular hyperplasia from prolonged estrogen therapy prescribed for epistaxis, post-transfusion acute and chronic infectious hepatitis with subsequent cirrhosis, hemosiderosis after multiple transfusions for chronic bleeding, passive congestion due to high output failure secondary to left-to-right shunting through arteriovenous fistulas.¹

Management of the hepatic encephalopathy associated with HHT consists of a protein-restricted diet, and treatment with either lactulose or neomycin. Limitation of episodes of epistaxis and gastrointestinal bleeding reduces the incidence of encephalopathy.□

References

1. Peery WH: Clinical spectrum of hereditary hemorrhagic telangiectasia (Osler Weber Rendu Disease). *Am J Med* 82:989-997, 1987.
2. Roman G, Fisher M, Perl DP, et al: Neurological manifestations of hereditary hemorrhagic telangiectasia (Rendu-Osler-Weber Disease). *Ann Neurol* 4:130-140, 1978.
3. Kandel G, Kortan P, Marcon NE: A confusing case of confusion. *Hospital Practice*, Feb 1983.
4. Fagel WJ, Perlherger R, Kauffmann RH: Portosystemic encephalopathy in hereditary hemorrhagic telangiectasia. *Am J Med* 85:858-860, 1988.
5. Michaeli D, Ben-Bassat I, Miller HI, et al: Hepatic telangiectases and portosystemic encephalopathy in Osler-Weber-Rendu Disease. *Gastroenterol* 54:929-932, 1968.

Department of Health Report . . .

(Continued from page 416)

is supported statewide through a grant from the CDC. Each quarter the program evaluates and reports progress toward the prevention of lead poisoning in children. To date, the prevalence of elevated lead levels (≥ 10 $\mu\text{g}/\text{dl}$) for children 6 to 72 months of age seen in health departments has declined from 12% to 8%.

Lead poisoning is a common and preventable threat to health in the pediatric population. In Tennessee, as across the country, progress is being made to eliminate this disease. While lead levels have declined in the general population, high-risk children can still be identified. The Year 2000 Objective for children ages 6 months to 6 years is to achieve a reduction in the prevalence of BLLs exceeding 15 $\mu\text{g}/\text{dl}$ to

1% of the children screened and reduce the number of children with BLLs exceeding 25 $\mu\text{g}/\text{dl}$ to zero. Through collaborative efforts among health care professionals, caretakers of young children, and state agencies, Tennessee can accomplish this goal.□

References

1. Case Studies in Environmental Medicine: Lead Toxicity. Atlanta, Agency for Toxic Substances and Disease Registry, 1990.
2. Needleman H, Riess J, Tobin M, et al: Bone lead levels and delinquent behavior. *JAMA* 275:363-369, 1996.
3. Brody D, Pirkle J, Kramer R, et al: Blood Lead Levels in the US Population, Phase I of the Third National Health and Nutrition Examination Survey. *JAMA* 272:277-283, 1994.
4. *Lead Poisoning in Young Children*. Atlanta, Centers for Disease Control and Prevention, US Department of Health and Human Services, 1991.
5. American Academy of Pediatrics. Treatment guidelines for lead exposure in children. *Pediatrics* 96:155-160, 1995.

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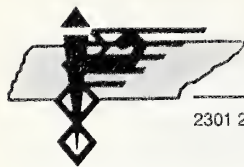
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Judy Light
AMA-ERF State Chairman
5315 Confederate Drive
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Letters to the Editor

Tobacco Abuse

To the Editor:

This letter is in response to the Department of Health Report, "Tobacco Use: Tennessee Youths at Risk," by Cornelia M. Pearson, R.N., M.N. published in the August issue of the *Journal (Tenn Med 89:299-300, 1996)*. I was very pleased to see an article addressing this particular problem. My only comment is a suggestion to replace the phrase "tobacco use" with a more accurate phrase "tobacco abuse." I have never been able to come up with any way to use tobacco, but only abuse it. Unlike alcohol and a great many other chemicals that can be both used and abused, tobacco seems to be strictly relegated to the abuse only category.

Larry H. Lee, MD
Methodist Regional Cancer Center
102 Vermont Ave.
Oak Ridge, TN 37830

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during August, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Terry C. Borel, MD, Johnson City
Richard D. Buchanan, MD, Brentwood
James F. Conrad, MD, Nashville
Charles E. Darling Jr., MD, Oak Ridge
Roy C. Ezell, MD, Hermitage
J. Vance Fentress, MD, Ardmore
Christopher W. Fletcher, MD, Nashville
Katherine W. Goff, MD, Monterey
Frank E. Jones, MD, Nashville
Charles A. Kirby, MD, Chattanooga
Joseph C. Loughheed, MD, Memphis
Roger E. McKinney, MD, Lebanon
Donald D. Owens, MD, Memphis
C. Leon Partain, MD, Nashville
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Jack C. Sanford Jr., MD, Memphis
Victor J. Thomas, MD, Chattanooga
Walter W. Wheelhouse, MD, Lawrenceburg
David R. Yates, MD, Hermitage

In Memoriam

Turley Farrar, age 82. Died August 23, 1996. Graduate of University of Tennessee College of Medicine. Member of Memphis-Shelby County Medical Society.

Sahin S. Kocacitak, age 63. Died July 8, 1996. Graduate of Medical Faculty, Ankara University (Turkey). Member of Chattanooga-Hamilton County Medical Society.

John S. McNulty, age 51. Died August 25, 1996. Graduate of University of California School of Medicine. Member of Bradley County Medical Society.

Ray Wallace Mettetal, age 79. Died August 21, 1996. Graduate of University of Tennessee College of Medicine. Member of Washington-Unicoi-Johnson County Medical Association.

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

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CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

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Alan F. Shikoh, MD, Chattanooga
Susan Stutes, MD, Chattanooga
Judy Washington, MD, Chattanooga

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Troy Elizabeth Brothers, MD, Columbia
Mark C. Nenow, MD, Columbia
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Yvette C. Sandoval, MD, Columbia

MONTGOMERY COUNTY MEDICAL SOCIETY

Bharatkumar R. Patel, MD, Clarksville

SCOTT COUNTY MEDICAL SOCIETY

Riad I. Homsy, MD, Oneida

SULLIVAN COUNTY MEDICAL SOCIETY

Brian M. Keel, MD, Kingsport

SUMNER COUNTY MEDICAL SOCIETY
Robert A. Grummon, MD, Lafayette

TIPTON COUNTY MEDICAL SOCIETY
Salman Saeed, MD, Covington

WILLIAMSON COUNTY MEDICAL SOCIETY
Kerry W. Gateley, MD, Franklin
Christopher A. Pierce, MD, Franklin

Personal News

Fred Ralston Jr., MD, Fayetteville, has been elected a Fellow of the American College of Physicians.

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program. TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Special Conferences/Seminars

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For information contact Division of CME, Vanderbilt University School of Medicine, D-8211 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

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- Jan. 9-11 High Risk Perinatal Seminar
- Feb. 17-20 Update in Obstetrics & Gynecology—Grand Caymen Island
- Feb. 23-28 Clinical Medicine—Kauai, Hawaii
- March 6-8 Symposium on Critical Care & Emergency Medicine—Hot Springs, Ark.
- March 8-15 Current Issues in OB/GYN—Snowmass Village, Colo.
- March 16-22 30th Review Course for the Family Physician

Knoxville

- Dec. 3-5 Perinatal Update '96—Gatlinburg
- April 23-25 20th Family Practice Update & Review—Gatlinburg
- June 6-10 13th Alzheimer's Disease Symposium—Gatlinburg
- June 12-14 42nd Great Smoky Mountains Pediatric Seminar—Gatlinburg

Chattanooga

- Dec. 5-6 Cardiology
- Feb. 23-26 Clinical Medicine—Kauai, Hawaii

March 7-8 Allergy & Immunology
March 20-21 Pediatrics

For information contact Mrs. Jean Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163, Tel. (901) 448-5547.

East Tennessee State University Continuing Education Schedule

April 18-19 Advanced Life Support in Obstetrics

For information contact Office of CME, James H. Quillen College of Medicine, East Tennessee State University, PO Box 70559, Johnson City, TN 37614, Tel. (423) 929-4341.



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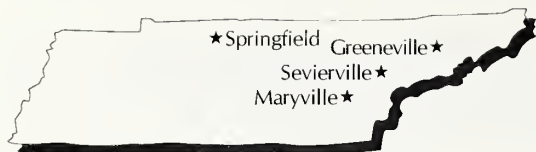
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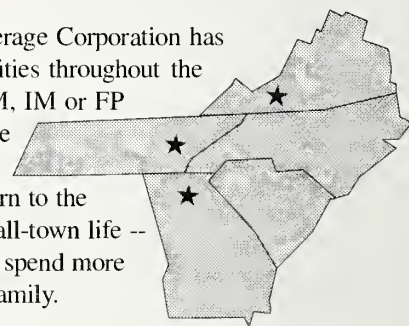
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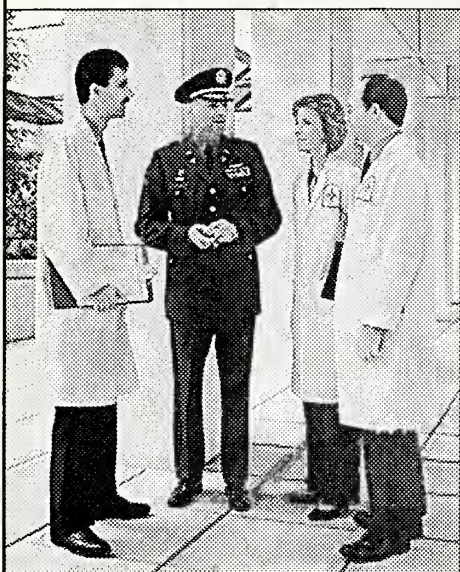
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Richard M. Pearson, MD

Stand Fast

This is the season of perpetual hope. For the vast majority of us, this time of year offers an opportunity for reflection and for renewed hope in our lives, in the lives of those we love, and for humankind. Our traditions and beliefs afford us a platform from which we can transcend the day-to-day crises and look at some eternal issues. These traditions were born out of epic events in which nations and peoples, oppressed by fear and power, were freed by hope and truth.

Hope, born out of endurance and courage, is the antithesis of fear. Approximately 15 years ago I remember reading about new concepts of health care delivery and a possible oversupply of physicians. The essence of the story was that this future would be a wonderful situation for both patients and physicians. Patients would have easy, timely, and unfettered access to rested, caring physicians. Physicians could reduce their hours along with their workload, function more effectively, still be adequately compensated, and have more time to spend with their families and worthwhile personal pursuits.

Nothing could have been further from the truth—so much for the predictions of futurists. Now patients and physicians are experiencing just the opposite situation. Confused, bewildered, fearful patients negotiate mazes of “gates” in order to obtain limited and specified products and services, but very little satisfaction or reassurance. Physicians are working harder, under enormous stresses, for less compensation and grudging respect. They are berated by the press, maligned by special interests, pursued by the plaintiffs’ bar, manipulated by business, investigated and intimidated by the government, and on occasion are unappreciated by suspicious, fearful patients. This has created a climate of fear in a profession of caring. Big government, big business, and the religion of big change have become the new purveyors of fear and of an old theology: might makes right.

Physicians are currently living and working in a climate of fear, but caring and fearing are essentially mutually exclusive phenomena. In our current vernacular the term for fearful living is “running scared.” Running connotes movement, but when combined with fear implies that we are probably moving in the wrong direction, away from the problem and not toward it. Unrestrained emotion, not thought, hope, or reason, is in charge.

William Cullen Bryant captured the message perfectly with these words “so live . . . that thou go not like the quarry slave at night, scourged to his dungeon, but (live) sustained and soothed by an unfaltering trust . . .” Physicians are not motivated by, educated for, or dedicated to “running scared.” Nor was humankind created to live fearfully. This is the central message of this special season: hope casts out fear, and there is reason to hope. Our profession seeks to take the essence of human experience and nurture it, protect it, and elevate it. We must not allow ourselves to be scourged to the dark corners of fear, but by example we must sustain and soothe those lives we touch.

During this holiday season remember your traditions—spiritual, personal, and professional. Endure. Find courage. Stand fast with hope in hard places.

R. Pearson MD

The Tennessee Medical Association

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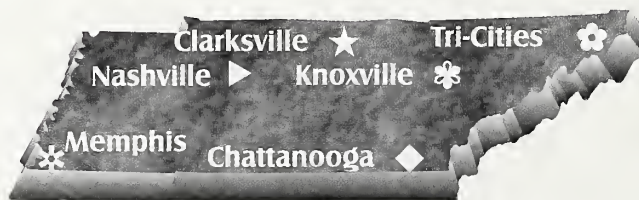
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John B. Thomison, MD

Scouting for Zebras

If you hear hoofbeats, it is more likely horses than zebras.

—Familiar medical aphorism

This afternoon as I rode home toward the west the sky above and ahead of me was nearly pitch black, except for an exposed strip of sky just above the horizon that was aflame from the setting sun. All the world underneath seemed a part of the conflagration. I rounded a curve, and it was gone. It did not return. Only once before have I seen its like.

Just before sunset some years ago I was walking along the nearly deserted esplanade above the beach at Nice, France. The afternoon had been rainy, and the sky, a deep blue-black, was beginning to take on a purplish tinge at the western end of the walkway, where a low semicircle was beginning to clear just above the horizon and extend out over the Mediterranean to the south. As the late afternoon sun reappeared from beneath the cloud bank, the recently cleared rim of sky rapidly filled with molten gold. It hung there, gradually widening, for nearly half an hour as the sun sank and disappeared, darkening sky, earth, and sea first to bronze and finally to scarlet, coloring the water and the foam of the breaking low waves in an ever-changing kaleidoscopic pattern and tinting the white facades of the hotels along the beachfront. It was like nothing I had ever experienced before, or since either, until today.

Sunsets are like that. Though sunsets are always more or less colorful, many, maybe even most, of them fail at stimulating the senses to a sharp edge and firing the imagination. However that may be, though some of them may remind you of others, and some are routine, none are ever the same. Fortunately for our patients, disease patterns are more predictable. Usually.

Albert Weinstein, MD, or "Big Al," as we called him, behind his back, of course, because he was, was a favorite teacher of mine, and in fact of most of the students in the clinical years at the Vanderbilt Medical School. For one thing, although looking down that long nose of his with those steely blue eyes he could be icy cold with his sharp, cutting wit toward an unprepared student, he was, in fact, a kind man who was genuinely interested in healing his patients and in teaching us how he did it when he did it, as well as why he couldn't when he didn't, which he was careful to show us is at least equally important. He was a superb diagnostician, who although he was supremely adept at the use of the technology of medical science in arriving at his diagnoses, always began with and emphasized the importance of a thorough medical history and physical examination to start with. His performance as the discussant at CPCs was legendary. Some of his colleagues, themselves often superb diagnosticians but less flamboyant, and therefore possibly sometimes out of jealousy, were heard on occasion to comment that, sure, he pulled that one out of his hat, but then he was always looking for zebras. In any case, his menagerie certainly did impress us.

Despite what the various ever-popular and spectacular medical series on the tube would, either deliberately or not, lead the unwary to believe, the practice of medicine, like every other occupation, is on the whole a rather pedestrian affair, and looking for zebras is a lot more fun than simply running with the horses. Thus our lionization of Big Al. It was not that we thought him necessarily a better doctor than others of our teachers. It was just more fun when, with his usual flair for the spectacular, he "pulled one out." The times he missed were easily forgotten. But when the zebra failed to materialize, the differential diagnosis in almost every case contained the proper horse.

There is, of course, a dark side to that force as well, which is the dreadful frustration and often the desperation and despair of watching the patient who has been the author of that excite-

ment go inexorably downhill to death, as so frequently those zebras defy medical wisdom, unlike the much larger numbers of the more predictable and tractable horses. This has been impressed upon me recently as I watch a friend sliding down the slippery slope with a disease that has defied classification and eluded all therapeutic attempts. The field of pathology affords the excitement of uncovering the occasional zebra among the horses without, at least in most cases, causing the pathologist to suffer the agonies of defeat that unsettle the clinician, though at the same time having to forego the thrill of victory. It is not that the pathologist is totally unaffected, but only that the involvement is vicarious.

Patients are much like sunsets, only different. Many, maybe even most, of them fail at stimulating the senses to a sharp edge and firing the imagination. Most of them remind you of others, which is how we make our diagnoses. Some are routine, but few if any are ever exactly the same. Fortunately for our patients, because there are a limited number of ways in which tissues can react to trauma, disease patterns are more predictable. Usually.

So, if you hear hoofbeats, they are nearly always from horses and not zebras. Unless you are in Africa.

For Each New Sunrise . . .

A digital clock shows nine AM in a brightly lit, luxuriously appointed bedroom. The occupant, suddenly wide-eyed, pops from the bed and bounds over to his computer, rapidly pressing the button labeled "Sunrise."

Nothing. Zip.

Insertion of the computer's plug into a receptacle in a large, red machine elicits a sigh of relief as the sun peeps over the rim of the hill, and, *Voila*, the world is bathed in sunlight. "Aren't you glad," breathes the white-robed, snowy-haired elderly gentleman who threw the switch, "that the Honda charger never sleeps?" Or something like that.

George Bernard Shaw, at least an agnostic, and more likely an atheist, observed that the noblest work of man is an honest god. Certainly the world's religious writings and iconography indicate man has consistently created his gods in his own image, and because man has seen himself to be a complex creature, he has more often than not found it necessary to have not one but multiple gods to encompass all of the frequently conflicting inconsistencies he sees within his own character, and which he must therefore ascribe to his god, or gods. The ancient gods are shown as either ogres, dragons, or supermen, with outsized human appetites and vices, who have habitually used the earth's inhabitants as playthings. Various deities have shown some sense of obligation toward various members or segments of humanity, but tended more toward using them, often against one another, to further their own ends and ambitions.

On the other hand, such an effete creature as the one attempting to initiate the sunrise described above would have been lost on those ancients. Yet that is how God is often portrayed these days: as a rather tired, sometimes a little confused oldster seemingly on the verge of, if not actually in, the early stages of Alzheimer's disease, and far, far from the omniscient, omnipotent, and omnipresent Creator and Sustainer of the universe depicted in Holy Scripture. Honda, indeed!

Albert Einstein, arguably the world's all-time greatest intellect, or at least in modern times, was convinced of the absolute predictability of the universe, and based his Nobel prizewinning General Theory of Relativity on it. He spent his last years trying to reconcile that with Max Planck's work with the Quantum Theory, which also won Planck the 1918 Nobel prize for physics, in which he showed that the laws of mechanics are sometimes either inoperative or markedly altered where very small bodies are concerned. In short, though the universe is gener-

ally orderly, that order is subject to lapses. Neither is it predictable. In recent years a whole new science of Chaos has grown up from this discovery, formalizing, though not necessarily solving, the riddles that have plagued statistical analysis, such as why, for instance, will heads and tails not only not come up with an equal frequency, but the discrepancy will continue to widen as the number of flips increases.

Such lapses were very frustrating to Einstein, who was convinced that God had created a perfect universe that could never deviate from its assigned pathways. God does not, he said, play dice with his creation.

Now God certainly does not need either Einstein or me to defend Him, but I do wonder sometimes what God must think about the things his creatures do to, by, in, for, and with His name. There are of course those who believe He doesn't even notice, or at least pay any attention to, anything that goes on "down here," even though Holy Scripture tells us He does. It tells us, for instance, that God will not hold him guiltless who takes His name in vain. For Him to do that, He would have to notice. My own opinion, which does not count for much, and which you can take or leave, is that if He thought anything at all about the commercial cited above, which I sort of doubt, any more than He would the brushing away of a stray gnat, it would likely do no more than elicit a chuckle. It is a tenet of the Church that work is prayer—not exclusively, of course—suggesting that what God is really interested in is what we do to and for His creation, by which we either honor or degrade His name, and not in our sometimes lame attempts at humor at His expense. God could not be a humorless being, else he would not for so long a time have put up with his wayward creatures, with our attempts to explain His ways. Scripture makes it plain that our thoughts are not His thoughts, neither are our ways His ways.

Else we would never have had Christmas. Unconditional love is a foreign concept except as it is shown us through God in Christ. Christmas is about Jesus joining His creatures and suffering with us in our often pitiful attempts to come to grips with a marvelously beautiful but often vastly unfriendly universe that is seldom improved much by our own tampering with it. Far from being an intervention of Honda, each new sunrise is God's promise of yet another day. It is why one of the forerunners of Christmas, the Winter Solstice, was celebrated by the ancients: the sun would not leave them in the cold, but was returning again for another year.

Christmas is the day of Emmanuel: *God with us*.

1996 TMA Membership Roster

1996 has been a year of change for TMA and its publications. In keeping with that trend and breaking from tradition, *Tennessee Medicine* has changed the manner in which the year-end TMA membership roster is printed and distributed.

For those of you who have relied on the December issue of the Journal in years past to provide you with a complete listing of members for the year, don't fear . . . simply contact the *Tennessee Medicine* staff at 1-800-659-1TMA for a copy of the 1996 TMA Membership Roster. TMA Component Medical Society secretaries will receive a roster for official records, and the official roster will be bound with the year's volume of *Tennessee Medicine* at the TMA Headquarters for posterity.

HMO Preparedness

Know Your Practice Inside & Out

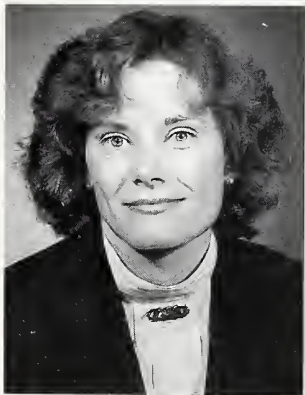
Irish Bahan

Twelve percent of the state's population is covered by HMOs and another third by PPOs. By the end of the year, these numbers will grow 16% because TennCare enrollees will be under HMOs. With all this activity, the industry is experiencing birth trauma not unlike that of any other new enterprise. As it matures, just like any other industry it will ultimately be shaped by the people—in this case, patients, legislators, and employers.

Perhaps you've already experienced the earliest growing pains—your own lack of baseline information to use in negotiations as you begin contracting, the endless bureaucratic snafus, your feelings of helplessness as HMOs seem to be able to move with no impunity in any chosen *direction du jour*.

The Power of Physicians

In the face of these constraints and others, physicians must reevaluate their own power, according to Carol O'Brien, senior attorney at the AMA. "Physicians should remember that their power rests in the fact that they ultimately advise patients," she says. Many times physicians don't realize how much their patients value their judgment and the information they provide on referrals, treatments, and self care."



O'Brien

As plans try to measure patient outcomes and patient satisfaction, those measurements are a direct reflection of the judgment and information provided by physicians, she continues. It's a cycle: a good physician/patient relationship is more likely to result

"Physicians should remember their power rests in the fact that they ultimately advise patients."

Carol O'Brien
AMA Director of Managed Care

in a good outcome, which is communicated to an employer and then to the HMO.

"Ask for help," O'Brien advises. "As an example, patients perceive that their care is better when they receive patient education. HMOs originally claimed to promote

wellness by *managing* care. Physicians should feel empowered to ask plans for patient education materials to help promote wellness."

An example of a California plan's proactive move to serve patients was the establishment of a 24-hour nurse hotline to reduce emergency room visits. ER usage was reduced by 35% and patients were extremely satisfied.

The Power of Data

Hard data is empowering. Developing your own baseline information conveys to a plan that you are aware of utilization concerns, that you are interested in cost-efficient practice, that you are willing to compare your standard data to the norms of the community. It shows a plan that you're willing to become a team player. O'Brien also recommends asking local employer groups for their claims data as an added source of information, and information-filled newsletters such as *Tennessee Managed Care* and *TennCare News* are available.

Day-to-day administration of a plan, with the necessity of quick and accurate information retrieval, is easier with good information systems. The last thing an HMO utilization review person on the phone wants to hear from a provider's office staff is that certain information is unavailable.

Pete Payne, chief administrative officer of The Sutherland Clinic, Inc., a Memphis cardiology group, was prepared with data when the clinic began negotiating a capitation rate with a plan in 1994. "They had good information on age, sex, and medical history and were open with it," he says. "As we looked at the 45,000 patients they represented, we had enough information to come up with a rate we could live with. Of course, that was just the beginning of the negotiation, but good data on both sides made it easier."

Payne cautions providers about negotiating risk contracts

Irish Bahan is a communications consultant who specializes in marketing and writing about health care.



Payne

with HMOs that simply do not have good data for analysis, and also with HMOs representing fewer than 20,000 lives, because there simply might not be enough people to spread the risk.

The practice in Memphis also uses their data to look at referral patterns and target their marketing to primary care physicians. To build and maintain referral relationships, the practice developed

protocols specifying appropriate referrals.

Payne, who is the former president of the Tennessee Medical Group Management Association, also is concerned with HMOs' communication with their subscribers. He would like greater emphasis on the basics, such as the necessity of referrals from PCPs bringing their subscriber card with them, and patients' responsibility for fees.

The maturing process of HMOs will be driven by regulation from both the state and federal levels as well as by market forces. O'Brien reports that legislative bodies across the nation are beginning to look at issues of HMO disclosure, financial incentives, exclusions, even treatments considered experimental.

Our free market society will shape and mold this chaotic and imperfect partnership even though the fiduciary goals are different: physicians must conform to the Hippocratic Oath and the ethics of their medical society, while the duty of for-

profit HMOs is to assure cost-effectiveness and quality of care and maximize profits to shareholders. Those physicians who empower themselves, understand the opposing pressures, and then work together will ultimately be ahead. □

For More Help on Managed Care...

For more help and information about Tennessee's managed care market, contact Phyllis Franklin, TMA's Manager of Third Party Reimbursement Services, at 1-800-659-1TMA.

The TMA offers its members a wide range of services on managed care and insurance.

Services include:

- Contract review services
- MCO fact sheets
- Seminars
- Personal office consultation

Harkey & Associates, Inc., of Nashville, is a managed care research and tracking company. John Harkey currently assists the TMA in its market tracking efforts and publishes *Tennessee Managed Care*, a quarterly publication outlining Tennessee's managed care industry, and *TennCare News*, a monthly publication covering TennCare developments. Harkey & Associates can be reached at 615-385-4131, PO Box 159025, Nashville, TN 37215.

HELP FOR PHYSICIANS

The Tennessee Medical Foundation Physicians Health Peer Review Committee assists doctors who are suffering from the disease of chemical dependence, or mental or emotional illness, or both, including certain behaviors problematic for physicians. The thrust of the program is rehabilitative, not punitive. The Committee is composed of physicians who have special expertise in these areas, some from personal experience. Effective treatment for these illnesses is achieved most easily when the disease or illness is detected early. The Committee urges family, friends, and associates to avoid misguided sympathy which enables a physician's impaired condition to deteriorate.

HELP US TO HELP

Call the TMF Physicians Health Program at (615) 893-7755 in Murfreesboro. Telephone message service available around the clock.

Loss Prevention Case of the Month

Did Socioeconomic Factors Influence Clinical Decisions?

J. Kelley Avery, MD



Dr. Avery is a member of the Loss Prevention Committee, State Volunteer Mutual Insurance Company, Brentwood.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured that it is presented solely for the purpose of emphasizing the issues presented.

Case Report

This man in his mid-20s who gave a history of living with a male companion was diagnosed as having had an embryonal cell testicular carcinoma which was removed in another city 10 months earlier. Following the operation, the patient received radiation and chemotherapy. A complete survey for metastases showed only some small periaortic nodes, which were unchanged from their preoperative appearance and size. He had been advised to follow up with a cancer specialist in the city to which he planned to move within six months, but had delayed this visit by about four months.

He presented himself to his new physician with a history of hemoptysis. He was found to have extensive pulmonary metastases and a mass in the right upper quadrant of the abdomen displacing the ureter to the right. The patient's father promised to pay his son's bill but "carried

on" about the young man's lifestyle. Six months of aggressive chemotherapy was planned and begun. There was gratifying response to the first course of chemotherapy. The markers were improved and the plan was to continue with the therapy.

After the second course of chemotherapy, there was a note in the patient's office record that "nobody has even made an attempt to pay some of the bills," and that the patient volun-

teered the father "may have lied to me." Treatments continued as planned for two more courses, after which there was remarkable clearing of the chest lesions and the periaortic nodes had decreased by 50% in size.

Just before the fourth of six planned treatments, the record states, "Asked about his bill" and "please try." The family was found to be very dysfunctional due to alcohol abuse. The physician had written several letters to various agencies on behalf of his patient, but on this occasion, when asked to write more letters, the physician refused because "no effort has been made to reduce the rising balance." "The father's promises were never fulfilled. Cost of our laboratory work, labor, and drugs has thrown us into a negative flow." The chemotherapy was repeated for the fourth time. The physician wrote to a state agency, "Due to a dramatic response to chemotherapy, I have suspended treatments. Current prognosis—he has entered into what we believe to be a prolonged remission."

A month later the patient noticed a mass in his right abdomen, which was confirmed by his doctor. The record indicated that the patient "wants to watch it." The plan stated in the record was to "recheck the mass and consider radiation or chemotherapy." Two weeks later the mass was essentially "unchanged, possibly smaller," and two weeks after that the physician recorded, "I think this needs definitive treatment. Discussed therapy. The patient states that the parents are destitute financially and emotionally. He doesn't want chemo."

Three months later, because the mass was found to be causing some obstruction to the right kidney, surgical removal was carried out. At this time the tumor marker, AFP, was markedly elevated. Another course of more aggressive chemotherapy was begun and continued for four cycles, but the marker continued to rise and further pulmonary lesions appeared.

The patient was then seen at another center and thoroughly evaluated. The consultant commented that there was an "unfortunate delay" between his examination where he was initially treated and the institution of chemotherapy, which he described as "at lower doses and longer intervals than we would believe to be optimal." He referred the patient to yet another center for possible bone marrow transplant. This

evaluation was underway when the patient filed a lawsuit against his physicians.

He was not considered to be a suitable candidate for the transplant, and died four months later, about two and one-half years after his initial surgery. Almost five years of litigation continued with the discovery of many "experts" on both sides of the matter. A long trial followed, resulting in a large award.

Loss Prevention Comments

Experts differ on the details of a case like this. Many considered the treatment given by the involved physicians to have been adequate. Others, however, thought that the delay in follow-up from the time of the first surgery, the choice of treatment protocol, and the delay between the discovery of the abdominal mass and its removal was below an acceptable standard of care.

The comments in the record relative to lifestyle, while truthful, may have been unnecessary. The recorded discussions of payment of bills and family matters should never have appeared in the clinical record. In this situation, although unfounded, it is easy for the jury and the lay public to conclude that factors other than the disease process entered into

the decisions regarding treatment. The jury award against the physician was very large, but the jury also found that the patient himself bore some of the responsibility for the delay in the initial follow-up after his move. Under the doctrine of comparative negligence, the award against the defendant physician was mitigated by the percent of negligence ascribed to the plaintiff patient. □

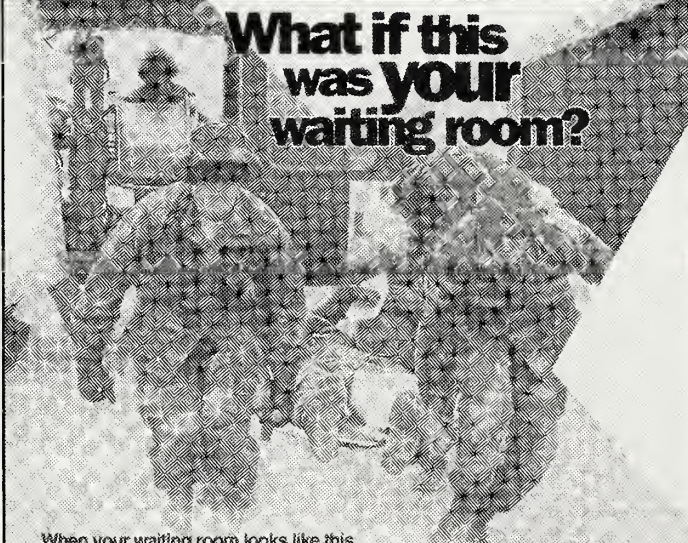
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AMA Fights for Physician Antitrust Relief

Department of Justice and FTC Redefine Antitrust Rules

Tim Sewell

Revised antitrust guidelines released on August 28 by the Federal Trade Commission (FTC) and the U.S. Department of Justice (DOJ) have opened the door to more opportunities for physicians who want to enter into joint ventures.

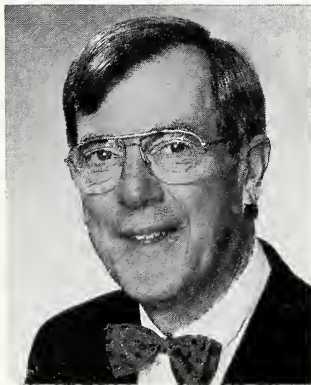
The revised antitrust guidelines address a number of issues. Basically, they reduce the amount of financial risk that must be assumed by physicians entering joint ventures, and they remove restrictions based on the size of the physician network. The new guidelines also have broadened the definition of substantial risk to include a number of options not previously available to physicians.

The revised guidelines are the result of an intensive three-year campaign by the American Medical Association aimed at removing barriers to physician joint venture networks. AMA president Daniel H. Johnson Jr., MD, says the revised guidelines should result in more choice for patients, more competition among providers, and better health care in general.

"Our persistence has paid off," Johnson says. "There is more to be done, but the agencies have done three things we asked for."

First, Johnson says, federal officials have acknowledged the fundamental changes that have taken place in the health care marketplace—in particular, the power of insurance companies and employers. They also have recognized the benefits to patients of ventures designed and controlled by physicians.

Secondly, officials have agreed not to hold physician joint ventures "per se" unlawful simply because they do not reimburse physicians under a capitation mecha-



Johnson

Mr. Sewell is a reporter for the Memphis Business Journal and writes frequently for the Memphis Health Care News.

What Caused Recent Changes?

- Changes in the health care marketplace that have empowered insurance companies and employers.
- Acknowledgment that patients may be served as well or better through physician-operated plans.

What Does this Mean for Physicians?

- Physicians will be able to develop, own, and operate health care insurance products and delivery systems to provide savings to employer/payers, with a reduced threat of legal repercussions, and offer beneficial competition and increased options to the marketplace.

nism, whereby physicians were rewarded for providing fewer services.

"Fee-for-service ventures and other kinds of arrangements will now be given an opportunity to demonstrate their merits under a 'rule of reason' test, if they are otherwise true joint ventures," Johnson says.

Third, the agencies will now permit physician joint ventures of the size necessary to be competitive.

"Patients want choice of physicians and plans," Johnson says. "The agencies will not block plans with 50% of physicians in competitive marketplaces. Insurance companies have never had to limit the size of their plans. The narrow 'safety zone' formulas are not to be taken in any way as maximum tests."

Johnson says it should be noted that the new antitrust guidelines represent a victory for the AMA over some competing interests.

"The new antitrust guidelines represent a defeat of an intense insurance industry campaign to block changes in policy," Johnson says. "Physician networks now have a great chance to compete effectively with commercial companies, and expand the range of choices available to our patients."

The three-year campaign by the AMA to revise the antitrust guidelines also resulted in the introduction of the "Hyde Bill" (HR 2925), sponsored by Rep. Henry Hyde (R-Ill), chairman of the House Judiciary Committee, with 153 bipartisan cosponsors. The bill would require a "rule of reason" approach to physician networks.

"While (the Aug. 28) action represents a milepost, we still have a way to go before we reach a level playing field," Johnson says. "The health care market is undergoing rapid changes. Antitrust and other regulatory policies will require even deeper adjustments. We will continue to work with Mr. Hyde and other congressional supporters on reasonable antitrust policy."

Tennessee Sen. Bill Frist (a Nashville surgeon) played a major role in convincing the FTC and the DOJ to develop the more flexible antitrust guidelines. Mark Tipps, Frist's chief of staff, says the senator first met with FTC chairman Robert Pitofsky several months before the revised guidelines were issued.

"At that first meeting, Sen. Frist gave his perspective as a physician and he urged them to remove some of the barriers so that we could open up more competition," Tipps says.

Sen. Frist met again with Pitofsky approximately three weeks before the guidelines were released in August.

"At the second meeting, FTC officials gave us a quick overview of what the new guidelines were going to sound like," Tipps says. "Sen. Frist said that they sounded positive and that he was anxious to see how they would come out."

"We have not yet had a chance to study these new guidelines in depth," Tipps adds. "Now, we're in an information-gathering mode and we'll just have to see how everyone reacts to them. But it would appear that they are certainly an improvement over the old guidelines."

As Tipps points out, the old guidelines limited physician networks to those where the physicians assumed substantial financial risk, and they placed limitations on joint ventures based on the size of the physician networks. The revised guidelines also expand the range of options available

"Physician networks now have a great chance to compete effectively with commercial companies, and expand the range of choices available to our patients."

Daniel H. Johnson Jr., MD
AMA President

to physicians.

"Overall, this seems to fit the needs of the market much better than the previous guidelines," Tipps says. "However, the guidelines are long and they're complex, and it will take some time for the attorneys and the marketplace to sort them out and see how well they work. But we're cautiously optimistic."

The revised antitrust guidelines also have the blessings of Sen. Fred Thompson. In a prepared statement, Thompson said that he agrees with physicians that current antitrust laws need reform in order to allow doctors to form networks and to compete for patients with HMOs and other managed care organizations.

"I voted to provide antitrust relief for provider-sponsored networks during the Medicare reform debate last year, and I support antitrust legislation similar to that sponsored by Rep. Henry Hyde in the House," Thompson says in the statement. "I hope that the new regulations issued by the FTC and the DOJ accomplish these goals. If they don't, Congress may have to reexamine this issue next year."

Marc E. Overlock, senior vice-president and general counsel for the Tennessee Medical Association, says he believes a number of Tennessee physicians will be interested in pursuing joint ventures under the new guidelines.

"I know there are a lot of physicians who have been interested in pursuing joint ventures," Overlock says. "Until now, they've been worried about investing in facilities. I think once the word gets out that these safe harbors are available and much expanded since last time, then physicians will think it's time to become more competitive in the market—instead of just caring for patients and signing all the managed care contracts they can."

Overlock explains that traditionally the Office of Inspector General of the U.S. Department of Health and Human Services has taken a dim view of physicians trying to invest in the market.

"They've been worried that that would lead to doctors making more money off of health care than they should," Overlock says. "Amidst that background, they came up with these safe harbors with the idea that there are types of physician investments that can benefit the community, and that without them we would not have a very competitive health care market. We would just have insurance companies and large corporations trying to run the whole show."

According to Overlock, these safe harbors promote physician efforts to coordinate in the market to provide services.

"These safe harbors say that as long as you're bearing

some amount of risk, then you as independent competitors can band together and form managed care products," Overlock says. "What these policies look for are benefits to the community and assurances that there is some type of risk that physicians bear as they come together."

Overlock says he is encouraged that the revised guidelines came about as a result of the efforts of the AMA to work with the FTC and the DOJ to modify the original safe harbors, which he describes as too restrictive. According to Overlock, the AMA's attorneys contacted each of the medical societies in the nation earlier this year asking for letters and communications from physicians who wanted to set up networks, but had shied away from doing so because they feared that they would violate the antitrust laws.

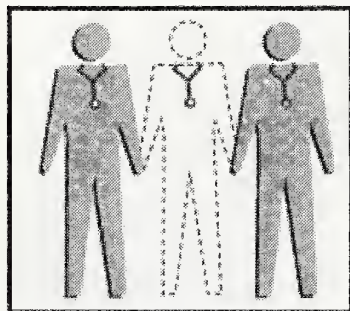
"We had several letters from physicians around the state who wanted to initiate doctor-generated ventures, but they were afraid to do so," Overlock says. "We didn't ask for

names. We just wanted examples. We forwarded those to the AMA."

With the revised guidelines, Overlock says physicians have a much wider range of business and investment opportunities. The future, he says, belongs to those groups that are willing and able to use their health care expertise to develop products providing substantial savings to employers.

"The FTC and the DOJ are looking for physicians who, given their unique market perspective, will be able to provide increased efficiencies to benefit the public," Overlock says. "They will take the middle man out of the picture and cut administrative costs that are absorbing a lot of the health care dollars. They will be able to provide care without a lot of oversight. But they must be efficient, because the efficient groups are going to be the ones to survive. I think Tennessee physicians will step up to the plate to meet that challenge." □

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Original Contribution

Recognizing Weber-Christian Disease

Chazali A. Khan, MD; Frances I. Lewis, MD

Introduction

Weber-Christian Disease (WCD) is a panniculitis of unknown etiology with two recognized forms. In localized types, the fever is accompanied by tender skin lesions and confined to the subcutaneous tissue. Systemic WCD implies a widespread process. Besides subcutaneous adipose tissue, the inflammation involves intravisceral fat, and presents constitutional symptoms and a constellation of clinical findings.¹ The pathogenesis of these lesions is not understood. The definitive diagnosis is based on histologic findings showing varying degrees of inflammation in the fat lobules and septa, as well as the presence of mononuclear cells and foam cells. Giant cell granulomas and fibroblasts are seen in severe cases. Vasculitis may be documented, which further separates panniculitis into other major groups. No uniformly effective therapy is recognized. The use of systemic steroids and nonsteroidal anti-inflammatory drugs during the acute stage of exacerbation is beneficial. A clinical course characterized by remissions and exacerbations of cutaneous lesions is frequent. The prognosis of WCD is variable, and is best when there is only cutaneous involvement. Prominent visceral involvement may eventuate in death due to sepsis, hepatic failure, hemorrhage, or thrombosis.²

From Woods Memorial Hospital, Etowah (Dr. Khan) and Cornell University Medical Center, New York (Dr. Lewis).

Reprint requests to Woods Memorial Hospital (affiliated with the University of Tennessee), Route 411 North, Etowah, TN 37331 (Dr. Khan).

ABSTRACT

The eponym Weber-Christian Disease (WCD) defines a chronic disorder characterized by relapsing febrile episodes and panniculitis. Systemic manifestations due to visceral involvement may be present. WCD is associated with no identifiable cause, although chronic panniculitis may be due to definable underlying disorders. A variety of distinctive disease entities, such as systemic lupus erythematosus (SLE), pancreatic disease, alpha-1-antitrypsin disease, lymphoproliferative neoplasia, infections, or trauma are associated with chronic panniculitis. The accurate diagnosis of panniculitis requires an adequate deep skin biopsy showing inflammation of the subcutaneous layers.

We describe a white woman with fever and recurrent episodes of painful nodules of the lower extremities, excisional biopsy of which confirmed panniculitis. The febrile episodes and skin lesions responded dramatically with the use of oral corticosteroids.

Case Report

A 70-year-old white woman had had numerous episodes of fever with arthralgia for two years, as well as multiple painful nodules over the right tibia. On each occasion she was treated with intravenous antibiotics for presumed cellulitis and phlebitis. Laboratory studies showed hemoglobin 11 gm/dl, WBC count 34,000/cu mm, platelets 104,000/cu mm, alkaline phosphatase 70 U/L (25-100 U/L), gamma glutamine transferase 80 U/L (5-65 U/L), aspartate transaminase 70 U/L (5-40 U/L), alanine transferase 45 U/L (5-35 U/L), lactate dehydrogenase 300

U/L (60-250 U/L), and normal clotting profile. Smith antigen and double-stranded DNA antibodies, rheumatoid factor, antimitochondrial antibodies, and HIV were not detected. Thyroid function was normal; amylase (300 U/L), and lipase (175 U/L). Blood cultures were negative, ESR was 70 mm/first hour, C4 complement was low, and VDRL was negative. Cryoglobulins and antineutrophilic cytoplasmic antibodies C and P types were not detected. Serum immunoglobulins, immunoelectrophoresis, and alpha-1-antitrypsin levels were normal. Coombs' test, TB skin test, pulmonary function tests, and upper and lower GI endoscopy were not informative. Chest x-ray showed right lower infiltrate. The diagnosis of WCD was based on recurrent skin nodules, fever, pancytopenia, high ESR, and elevated transaminases. An excisional skin biopsy revealed adjacent fat lobules having widely varying degrees of inflammation consistent with panniculitis.

Discussion

WCD is an infiltrative, inflammatory disease affecting white women after the second decade. It characteristically

has recurrent febrile episodes and erythematous subcutaneous nodules. Recurrent crops of symmetrical, tender lesions 1 to 2 cm in size may appear in any area. There is a predilection for the lower extremities and trunk. These nodules rarely suppurate, and spontaneous regression can be expected. This resolution results in a hyperpigmented atrophic scar that is depressed consequent to subcutaneous fat necrosis. WCD implies systemic involvement when the skin lesions are accompanied by arthralgia, myalgias, and abdominal pain. Liver involvement may produce hepatomegaly, weight loss, and nausea. Involvement of perivisceral fat, serosa, including that of the pericardium, pleura, mesentery, and omental fat is common. Involvement of the bone marrow may produce anemia, leukocytosis, or leukopenia and bone pain. In severe instances, the inflammation can involve the lungs, myocardium, spleen, kidneys, and adrenal glands.³

The etiology of WCD remains unknown, but it has been proposed that it results from an immunologically mediated reaction to diverse antigenic stimuli. An association with elevated levels of circulating immune complexes has been reported. The similarity between WCD and cases of alpha-1-antitrypsin deficiency suggests that an altered regulation of the normal inflammatory process could play an etiologic role. The diagnosis, which requires a deep skin biopsy including the subcutaneous fat and fascia, is essential. The histologic characteristic is the location of the inflammatory focus. When inflammatory cells are located primarily in fat lobules, the panniculitis is called lobular, whereas inflammation in the septa is termed septal panniculitis. The presence or absence of vasculitis further differentiates panniculitis into different major groups. Visceral involvement in WCD can be proven with difficulty, requiring more invasive procedures, and at times even laparotomy. There is a daunting clinical sameness to the different types of panniculitis, since many at some stage of development present as erythematous subcutaneous nodules on the legs. These lesions begin with acute inflammation, followed by a granulomatous stage featuring foamy macrophages, and then resolve with varying degrees of fibrosis. The histologic septal-lobular dichotomy is sometimes diagnostically useful, but more often there is a mixed picture that adds to interpretive difficulties. When histologic classification of panniculitis is made, it forms the basis for a logical clinical approach.⁴

Panniculitis syndromes are of diverse etiologies that share many clinical, inflammatory, and immunologic features. Therefore the diagnosis of WCD, like that of "vasculitis," requires a careful search for additional associated or distinctive clinical entities. Common causes of erythematous subcutaneous nodules are numerous, ranging from inflamed epidermoid cysts to furuncle. Lesions that mimic them include lupus profundus, erythema nodosum, erythema induratum, pyoderma gangrenosum, cutaneous polyarthritis nodosum,

alpha-1-antitrypsin deficiency, and the rare Rothmann-Maki syndrome affecting children. Lupus profundus, a clinical variant of systemic lupus erythematosus (SLE), involves the overlying dermis and epidermis in areas of abundant fat. Erythema nodosum lesions are located over the anterior tibia, which neither ulcerate nor heal with a scar. Pyoderma gangrenosum, considered non-infectious in origin, clinically exhibits a painful nodule or pustule that ulcerates and drains purulent exudate and has a necrotic base. Erythema induratum is characterized by nodules located on the calves, and is usually associated with tuberculosis.⁶ In alpha-1-antitrypsin deficiency panniculitis, recurrent tender indurated nodules are widely disseminated on the trunk or extremities. New lesions appear as old lesions resolve. This condition is usually associated with pan-lobular emphysema and hepatic disease. In a substantial number of patients, lesions become necrotic, draining an oily, brown fluid; this variant is termed liquefying panniculitis.

The involvement with systemic disease can be divided into several categories: (1) collagen vascular disease, (2) alpha-1-antitrypsin deficiency, (3) pancreatic disease, (4) generalized lipodystrophy, (5) paraproteinemia with C-1 inhibitor deficiency, (6) lymphoproliferative disease, (7) eosinophilic fascitis, eosinophilic myalgic syndrome, (8) rare causes, which include gout, calciphylaxis of chronic renal failure, familial Mediterranean fever, Nasu disease, atheromatous emboli, and acquired immunodeficiency syndrome, (9) infections, including those caused by deep fungi and mycobacteria, (10) pharmaceutical agents (glucocorticoids, aspartate, and pentazocine), (11) physical panniculitis and Sweet's syndrome, and (12) panniculitis with vasculitis, including superficial migratory thrombophlebitis, and polyarteritis nodosa.

The laboratory findings are nonspecific, reflecting either acute or chronic inflammation. Markedly elevated ESRs, anemia, leukocytosis or leukopenia, and thrombocytopenia are detected in mild cases. When visceral involvement occurs, more pronounced laboratory abnormalities may develop. Elevated serum and urine amylase, and lipase are helpful in differentiating WCD from the panniculitis associated with pancreatic disease, which includes acute and chronic pancreatitis, acinar cell pancreatic carcinoma, pancreatitis secondary to cholelithiasis, post-traumatic lesions, pseudocyst, and congenital pancreatic abnormalities. Skin biopsies in these cases disclose acute fat necrosis with characteristic ghost cells.⁵

Normal alpha-1-antitrypsin levels help to distinguish WCD from alpha-1-trypsin deficiency panniculitis. Patients with alpha-1-antitrypsin deficiency may have only dermatologic manifestations of panniculitis. The genetic phenotype recognition is important, as patients with the PiZZ variety deficiency are associated with pan-lobular emphysema. In panniculitis associated with connective tissue disorders, lupus erythematosus is the most common.⁶ Panniculitis is more

commonly associated with discoid lupus erythematosus than with SLE. In some SLE cases, hypocomplementemia and circulating immune complexes are seen. Our patient had a persistently low fourth component of complement, not a well recognized feature of the disease. A recent review of WCD cases reported a significant hypocomplementemia (C3 and C4), in addition to circulating 7S IgM at the time of relapse. It is of interest that a hereditary deficiency of C4 is often associated with systemic lupus, or a lupus-like syndrome, and SLE is probably the most common identifiable cause of panniculitis. However, our patient did not have the clinical or laboratory features of SLE at any time during the course of her illness.

Moreover, on each occasion the skin lesions in our patient were accompanied by radiographic evidence of segmental pulmonary parenchymal infiltrates. Repeated sputum analysis was negative for bacteria, malignant cells, and fungi. No response to systemic antibiotics was seen, but steroids produced prompt resolution of the infiltrate.⁷ We believe that the pulmonary findings were a part of systemic manifestation. Other features of systemic WCD in our patient included elevated liver enzymes and pancytopenia. Hepatosplenomegaly, steatorrhea, and intestinal perforation have also been reported. Visceral involvement may be confined to retroperitoneal spaces, causing ureteric obstruction and retroperitoneal fibrosis. Mesenteric panniculitis results in abdominal pain, diarrhea, and constipation.⁸

In some reported cases of WCD, patients exhibited features of a distinct entity known as histiocytic cytophagic panniculitis (HCP), which is characterized by panniculitis, fever, serositis, reticuloendotheliomegaly, and coagulation defects. The characteristic lesion is the "bean bag" histiocyte, containing ingested lymphocytes, red cells, and platelets. While some of these patients have a benign course, the majority die of hemorrhagic complications. Infiltrating T lymphocytes in HCP are of clonal origin, suggesting that subcutaneous T cell lymphomas are a malignant counterpart or a late transformation phase of HCP.⁹

The prognosis of localized WCD is good. Remissions and exacerbations are frequent, as some patients recover after a

few months and permanent remission is usual after several years. On rare occasions systemic involvement may be fatal. There is no specific therapy, though numerous recommendations have been made, including saturated potassium iodide for cutaneous lesions. Hydroxychloroquine has also been advocated as treatment, and high-dose prednisone has been reported to be of value in severe cases. Danazol, a synthetic androgen derivative, has been prescribed for alpha-1-antitrypsin deficiency. Some success has also been reported with dapsone therapy, and anecdotal reports suggest that cyclosporine may be of value in some severe systemic instances.¹⁰

In summary, patients with febrile episodes and recurrent subcutaneous nodules should have excisional biopsies to establish a histologic diagnosis, with an extensive work-up in cases where panniculitis may be a sign of underlying systemic disorders. A careful search should be made for additional associated or distinctive clinical entities relating to a rheumatologic, immunologic, or malignant process. The prognosis for WCD is variable. Establishing the diagnosis of panniculitis and initiating appropriate treatment in the localized variety has a better prognostic course, but panniculitis associated with prominent visceral involvement may eventually lead to death. □

Acknowledgment

The authors wish to thank Mary Walsh for secretarial assistance.

References

1. Panush RS, Yonker RA, Dlesk A, et al: Weher-Christian disease. Analysis of 15 cases and review of the literature. *Medicine* 64:181-188, 1985.
2. Patterson JW: Panniculitis. New findings in the "third compartment." *Arch Dermatol* 123:1615-1617, 1987.
3. Theron H, Du T, Steyn AF: Systemic nodular panniculitis (Weher-Christian Disease) in a black woman. *SAMJ* 68:338-340, 1985.
4. Bundi EE, Lazarus GS: Disorders of subcutaneous tissue, in Fitzpatrick TB, Eisen AZ, Wolff K, et al (eds): *Dermatology in General Medicine*, ed 4. New York, McGraw-Hill, 1993, pp 1329-1344.
5. Walsh N, Towers RP, McCabe M: Systemic Weher-Christian disease with pancreatic and adrenal invasion. *Irish J Med Sci* 154:406-408, 1985.
6. Shields RC, Su WPD: A 35-year-old woman with ulcerating skin lesions. *Mayo Clin Proc* 71:59-66, 1996.
7. Sorensen RU, Abramowsky CR, Stern RC: Ten-year course of early-onset Weher-Christian syndrome with recurrent pneumonia: a suggestion for pathogenesis. *Pediatrics* 78:115-120, 1986.
8. Brawn LA, Ramsey LE, Shortland JR, et al: Systemic Weher-Christian disease with reversible bilateral ureteric obstruction. *Postgrad Med J* 65:410-416, 1989.
9. Alegre VA, Winkelmann RK: Histiocytic cytophagic panniculitis. *J Am Acad Dermatol* 20:177-185, 1989.
10. Farmer KL: Additional tests of interest to the dermatologists. *Dermatol Clin* 12:191-199, 1994.

1996 TMA Membership Roster

1996 has been a year of change for TMA and its publications. In keeping with that trend and breaking from tradition, *Tennessee Medicine* has changed the manner in which the year-end TMA membership roster is printed and distributed.

For those of you who have relied on the December issue of the Journal in years past to provide you with a complete listing of members for the year, don't fear . . . simply contact the *Tennessee Medicine* staff at 1-800-659-1TMA for a copy of the 1996 TMA Membership Roster. TMA Component Medical Society secretaries will receive a roster for official records, and the official roster will be bound with the year's volume of *Tennessee Medicine* at the TMA Headquarters for posterity.

Department of Health Report

Newborn Screening in Tennessee

H. Lee Fleshood, PhD, MPA

The Tennessee Department of Health (TDH) is responsible for implementing state laws requiring all newborn babies to be tested for four genetic disorders before leaving the hospital. Phenylketonuria (PKU) testing was begun in 1968, followed by hypothyroidism in 1980, hemoglobinopathies in 1988, and galactosemia in 1992. In 1995, when 77,653 initial and 7,403 repeat screenings were performed, it is estimated that the identification of one baby with galactosemia, five with PKU, 16 with hypothyroidism, and 76 with hemoglobinopathies resulted in a savings of approximately \$12,450,000 in acute and long-term care, in addition to the reduced physical and emotional trauma to the children and their families.

Tennessee state law requires that every infant must have a newborn screening test performed after 24 hours of age and before discharge from the hospital regardless of age. The law further requires that all infants leaving the hospital before 24 hours be re-screened within two weeks. It is important to note that the detection of an elevated level of galactose is dependent on the newborn having had lactose feedings before the specimen is collected. If a "soy formula" is the beginning formula, the method used for screening will not detect a galactose metabolic defect.

In the case of a premature infant, an infant on parenteral feeding, or any newborn being treated for illness who is not discharged from the nursery, the specimen should be collected on or near the seventh day of age. The responsibility for submitting a specimen to the state laboratory is assigned to the chief administrative officer and the attending physician. They are also responsible for informing the parent(s) that a re-screening is necessary if the specimen was collected before 24 hours. Babies not born in a Tennessee hospital must be tested within two weeks of birth.

An infant with an unsatisfactory result is considered unscreened. Of the 7,403 unsatisfactory screening tests in 1995, 2,171 were collected at less than 24 hours of age because of early discharge. Each quarter, hospitals are sent data on unsatisfactory screens to assist them in identifying specific errors in collection technique, documentation, or other

procedures that may have contributed to the unsatisfactory result. The newborn screening laboratory results are mailed to the hospital of collection and to the physician. Physicians and parents are notified by follow-up letter when infants require repeat testing because of borderline or unsatisfactory specimens, or if a transfusion was given prior to the test. Infants with highly suspect or presumptive positive results are immediately reported by telephone to the physician so that further testing can be expedited. This telephone call is followed by a certified letter.

In addition, tertiary centers are notified by telephone and letter of presumptive positive screens, and physicians also receive information on endocrinologists and the genetic and sickle cell centers in that city or region. There are TDH contracts with genetic/metabolic centers at the University of Tennessee in Memphis and Knoxville, and Vanderbilt University in Nashville to provide consultation, confirmatory testing, and treatment for suspected PKU, galactosemia, and Duarte/galactosemia. In addition, two other genetic centers, T.C. Thompson Children's Hospital in Chattanooga and East Tennessee State University in Johnson City, provide consultation, treatment, and follow-up to families.

Meharry Comprehensive Sickle Cell Center in Nashville performs confirmatory testing statewide for hemoglobinopathies, and is also a regional sickle cell center. Regional sickle cell centers are available for consultation, treatment, and follow-up. In addition to Meharry, regional centers include Mid-South Sickle Cell Center in Memphis, T.C. Thompson Children's Hospital, and UT Knoxville Developmental and Genetic Center.

To insure timely identification and treatment of infants with genetic or metabolic disease, it is imperative that adequate blood samples and accurate demographic information be obtained on the initial screening test. Early hospital discharge and unsatisfactory tests contribute to the need for continued cooperation of providers to locate infants for follow-up testing. Name changes and/or changes of address may slow the repeat process. Local health departments can assist providers in locating or retesting these infants.

The TDH Newborn Screening Coordinator is available to assist providers in interpreting test results and in obtaining appropriate follow-up. Program staff will also be available to

(Continued on page 456)

From the Tennessee Department of Health, Nashville. Dr. Fleshood is director of the Genetics and Newborn Screening Program.

Stroke Prevention Series

Acute Stroke Intervention

Kenneth J. Gaines, MD

Introduction

The concept of acute stroke treatment has undergone a revolution over the past several years, and there is promise for continued revolutionary developments over the next few years. The major developments have been first the use of thrombolytic therapy for ischemic stroke similar to that used in myocardial infarction, as well as the research interest in cerebral protective agents. Use of these agents in animal models has better defined the appropriate use of these drugs in acute ischemic stroke, and has led to clinical trials in ischemic stroke patients.¹ The FDA approval in June of 1996 of t-PA for use in ischemic stroke within three hours of onset was a landmark culminating many years of research in this field by numerous investigators. Much research remains to be done to define the stroke patients with the best chance of improvement with t-PA and with the least chance of side effects, mainly the hemorrhagic conversion of an infarct. The hope is that the numerous ongoing clinical trials of cerebral protective agents will yield one or more agents that can decrease cerebral damage and/or lengthen the time window for effective use of thrombolytic agents. This article will review the animal and human studies that are the underpinning of this revolution in stroke care.

Animal Experimental Data

The concept of cerebral protection and the use of thrombolysis in stroke is based on the premises that: (1) there is a short time interval (therapeutic window) after the onset of ischemic stroke during which there is a paralysis of brain function ("stunned brain") but without tissue death, and (2) that surrounding an area of dead brain tissue in a brain infarct there is an ischemic penumbra of marginally viable tissue that is metabolically deranged but could be salvaged with the appropriate therapeutic maneuvers.² Animal models of ischemic stroke have been utilized to support both of the above premises.³ Differences between species are known to exist and

a direct link from the animal data to the stroke patient is not always clear. Nevertheless, studies in several animal models have shown that tissue death in the brain after infarction is a gradual and gradable process that can be modified at several points. Fig. 1 is a diagrammatic representation of the process of brain infarction in the monkey with an early stage of tissue injury having paralysis of function (paralysis of a limb, for example) but with potential for recovery if blood supply is reestablished or the ischemic metabolic cascade leading to tissue death is modified.⁴ Although the time window varies with the species of animal, experimental embolus models of stroke have shown that animals receiving thrombolytic therapy in the first few hours after stroke have less tissue damage than animals not receiving thrombolysis.⁵ Just as importantly, these studies have shown that thrombolysis can open experimentally occluded cerebral vessels safely and can decrease infarct size without increased hemorrhage into ischemic brain. These studies have been the basis for recent interest in use of thrombolysis for stroke.

Clinical Studies of Thrombolysis

The use of thrombolytic therapy for stroke is not a new idea. Table 1 shows a summary of early thrombolytic studies in stroke cases and includes the agents used and the therapeutic windows employed. Early clinical attempts to use these

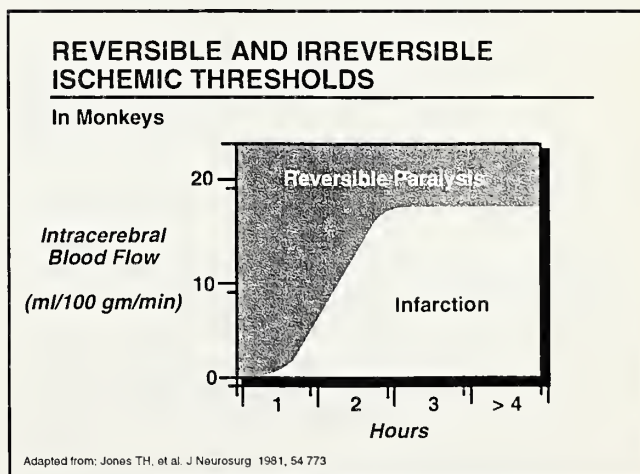


FIGURE 1

From the Department of Neurology, University of Tennessee College of Medicine, Memphis. Dr. Gaines is a member of the Tennessee Stroke Task Force, which is supported by the American Heart Association.

Reprint requests to The Neurology Clinic PC, 80 Humphreys Center, Suite 320, Memphis, TN 38120 (Dr. Gaines).

TABLE 1
"Controlled" Trials of Thrombolysis for Acute
"Ischemic" Stroke*

AUTHOR	DRUG	ROUTE	DOSE	TIME ONSET	OUTCOME MEASURE	RESULTS			
						TREATED No.	TREATED %	CONTROL No.	CONTROL %
MEYER, 1963	Fib/Pla	IV	2.5-11.5 x 10 u	<72 hrs	Clinical improvements at 10 days	20	45	20	45
MEYER, 1961	SK	IV	2.5-17.5 x 10 u	<72 hrs	Clinical improvements at 10 days	37	43	36	58
OHTOMO, 1985	UK	IV	6 x 10 u per day for 7 days	<6 hrs	Clinical improvements at 4 weeks	19	47	12	25
MORI, 1992	tPA	IV	34-50mg	<6 hrs	Recanalization	169	56	181	42
ABE, 1981	UK	IV	6 x 10 u per day for 7 days	<30 days	Clinical improvements at 1 and 4 weeks	54	63	53	43
JTSG, 1994*	tPA	IV	34 mg	<6 hrs	Clinical improvements at 4 weeks	51	72	47	55

*References available from the author upon request.

agents were limited by the lack of understanding of the pathophysiology of acute ischemic stroke and the time windows for effective and safe use of these agents. This led, for example, to time windows for treatment that would seem clearly too long by current standards. Also, many of these studies lacked the rigorous use of CT scanning to include patients with some chance of recovery and exclude those with excessive bleeding risk.

Not all recent clinical studies of thrombolysis in ischemic stroke have yielded positive results, however. Table 2 summarizes recent trials of thrombolysis in cerebral infarction. Important information for use in evaluating these studies includes the thrombolytic agent used, the dosage of the thrombolytic agent, and the delay in beginning treatment. In addition, the studies used different criteria to exclude patients based on CT scan appearance, and may have studied slightly different stroke populations. Future rigorous comparisons of these trials may shed light on whether these factors are important in treating patients using thrombolysis.

The two major positive trials of thrombolysis in ischemic stroke were the National Institutes of Health sponsored t-PA Acute Stroke Trial (NIH Trial)⁶ and the European Cooperative Acute Stroke Study (ECAS).⁷ The NIH Trial was instituted after a pilot dose-finding study and used t-PA at a dose of 0.9 mg/kg infused over one hour with a 10% initial bolus. Patients appropriate for t-PA based on this study had an ischemic stroke with a *clearly defined time of onset* known to be less than three hours from onset of stroke until treatment begins. Inclusion and exclusion criteria are given in Fig. 2. Documenting time of onset is important and not as easy in practice as in theory because patients and family often understandably may not have an accurate idea of when symptoms began. For example patients awakening with symptoms cannot accurately know time of onset, and time when last

TABLE 2
Thrombolytic Trials in Stroke*

TRIAL	AGENT	DOSE	TIME	OUTCOME
MAST-E (Hommel, 1994)	Streptokinase	1.5 MU IV	6hr	Stopped due to excess mortality and hemorrhage in treated patients.
AUSTRALIAN (Donnan, 1995)	Streptokinase vs Placebo	1.5 MU IV	4hr	Stopped due to excess risk in treated patients in the 3rd-4th hour period for hemorrhage.

*References available from the author upon request.

awake must be assumed as time of onset. The CT scan interpretation is also critical, and small areas of hemorrhage must not be missed, especially in the brainstem on a CT that may have some motion artifact. Fig. 3 shows an example of a CT that was interpreted as normal but shows a hemorrhage in the brainstem that was much larger on the scan four hours later. Careful CT interpretation by an observer experienced in CT interpretation in the setting of acute stroke is essential to avoid disastrous complications of this therapy.

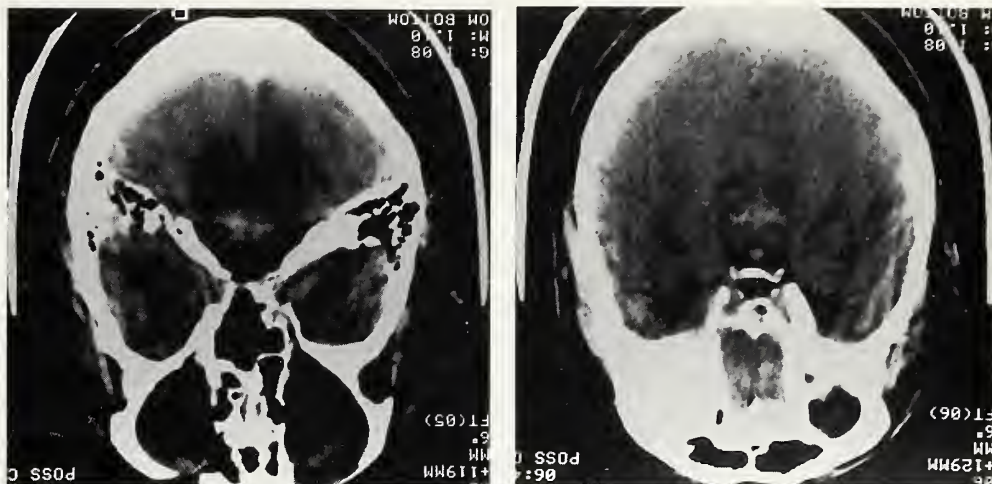
The results of the NIH t-PA Study are shown diagrammatically in Figs. 4 and 5. There was a statistically significant difference in the number of patients with a good outcome (defined as a small neurologic deficit and good functional outcome on four rating scales) in the treated group compared to placebo. This improved neurologic outcome occurred without a greater all cause mortality in the treated than in the placebo group. It is difficult to show the same sort of treatment effect on mortality in stroke patients as in myocardial infarction patients, because most stroke patients do not die directly from their stroke but rather from heart disease or from complications of their stroke. Therefore, it is not surprising that the study showed no impact positively or negatively on mortality. Stroke is a disabling illness, and treatment that decreases disability represents a significant treatment effect.

FIGURE 2
NINDSS rTPA Acute Stroke Trial⁶

Exclusion Criteria

1. No trauma in three months prior to stroke;
2. No major surgery in 14 days prior to stroke;
3. No history of intracranial hemorrhage;
4. Systolic BP <185 mm Hg, diastolic BP <110 mm Hg at start of treatment;
5. No arterial puncture;
6. No history of GI or GU bleeding in prior 21 days;
7. No history of seizure, use of anticoagulants, or heparin;
8. No elevated PTT, PT > seconds
Platelets <100,000
Blood sugar <50 or >400
9. No rapidly improving symptoms.

Figure 3. A CT scan that was interpreted as normal (left), but showed a hemorrhage in the brainstem that was much larger on the scan four hours later (right).



As shown in Fig. 5, use of the drug will improve outcome, with little or no disability in 11 more patients for every 100 treated, as compared to the placebo group, resulting in a 12% absolute or a 32% relative increase in the number of patients with a good outcome. The results were true regardless of age or stroke subtype (including lacunar infarction). The study was intentionally designed to keep the technology involved in treatment simple and readily available. No angiography was required for treatment, and limited laboratory studies (PT, PTT, platelet count, blood sugar) are needed to institute treatment. Although the exclusion criteria are largely clinically based, and may seem deceptively simple, scrupulous attention to these criteria is vital to the success of treatment.

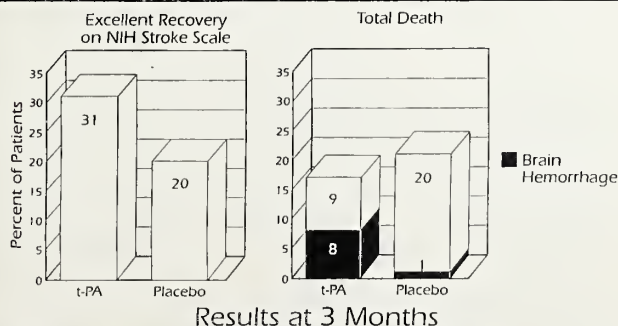
There will be side effects of treatment in the form of hemorrhagic conversion of an ischemic infarct. Table 3 gives a summary of hemorrhage rates in several of the major recent clinical trials using various agents. The hemorrhagic conversion is of two types: transformation of a petechial hemor-

rhage due to small non-confluent areas of hemorrhage, usually occurring without clinical symptoms, and a parenchymal hemorrhage due to a large mass of blood, almost always with clinical deterioration. No heparin was given to patients in the NIH Study (no subcutaneous or low-dose heparin) for 24 hours after treatment. Although the rate of asymptomatic hemorrhagic transformation was the same in the treated and placebo groups, symptomatic parenchymal hemorrhage occurred more often in the treated group (7% vs 1%) ($P < 0.001$). The symptomatic parenchymal hemorrhage was seen more frequently in those patients with a more severe deficit, and in those patients with CT evidence of edema on the pretreatment scan. Fatal parenchymal hemorrhage was more common in the treated than in the placebo patients (3% vs 1%). Serious systemic bleeding was also more frequent in the t-PA group than in the placebo group (1.6% vs 0%).

It should be recognized that hemorrhagic transformation also occurs in the natural history of ischemic stroke without

FIGURE 4

NINDS t-PA Stroke Trial

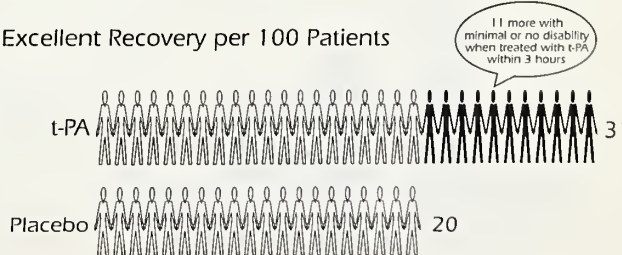


Source: National Institute of Neurological Disorders and Stroke

FIGURE 5

t-PA Treatment for Acute Stroke

Excellent Recovery per 100 Patients



NIH Stroke Scale Results

Source: National Institute of Neurological Disorders and Stroke

TABLE 3
Thrombolytic Trials in Stroke*

Trial	Agents	Dose/Route	Time	Outcome	Parenchymal Hemorrhage
ECASS (JAMA 1995)	rtPA	IV 1.1mg/kg	6hr	no differences in intention to treat analysis	19% 6.5%
NINDS (NEJM, 1995)	rtPA	IV 0.9mg/kg	3hr	Good outcome 1.9 or for favorable outcome	Mortality 17% D 21% P 6% A 0% P
MAST-I (LANCET, 1995)	Strep	1.5 MU IV	6hr	6 mo case fatality and disability 62% D 63% D & ASA 60% ASA 68% P	NS Diff. 6% D 10% D+ASA 2% ASA 0.6% P
PROACT (del Zoppo, 1996)	Prouk	Infusion to lyse	6hr	Full recovery 31.9% D 21% P	Mortality 27% D 43% P Recanalization 58% D 14% P

*References available from the author upon request.

the use of any treatment, either thrombolysis or anticoagulation. Most autopsy studies have shown an 80% to 90% incidence of some hemorrhagic change. Clinical studies using repeated follow-up CT scans have shown that about 40% of ischemic stroke patients will have CT-documented hemorrhage at some point in the 30 days following stroke, usually before two weeks after onset. Some preliminary work has been done defining the reasons for this, and identifying modifiable factors that could reduce the incidence of hemorrhagic conversion, but further work must be done to understand this more fully and translate it to meaningful information for treating patients. It has been proposed that size of the infarct, degree of collateral circulation, and time to reperfusion of the occluded vessel may play a role.⁸ Current information suggests that since large infarcts with good collateral circulation and late reperfusion may all have an increased tendency to hemorrhagic transformation, these patients should be approached cautiously for thrombolytic therapy. It should be stressed that the outcome of treatment with t-PA was good even considering the hemorrhages that appeared as a com-

FIGURE 6
Thrombolytic Trials in Stroke
NINDS vs ECASS

Possible reasons for the lower hemorrhage rates in NINDS:

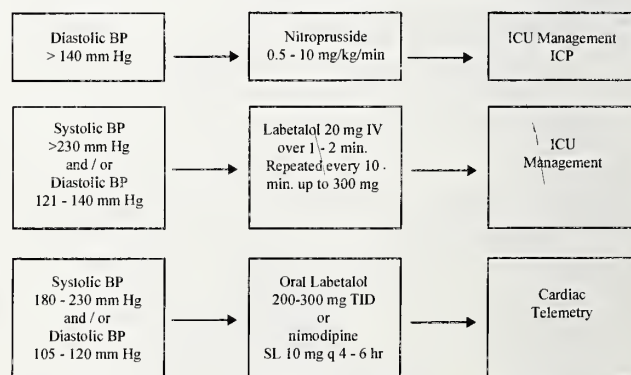
1. Lower dose
0.9 mg/kg vs 1.1 mg/kg
2. Time to treatment
Three-hour vs six-hour window
3. Patients management differences
BP management differences
4. Different populations
Different severity
Different subtypes of stroke
Different risk factors

plication of treatment. Thus, it appeared that the number of treated patients who moved into a good outcome category overshadowed the number of patients made worse by hemorrhage, and that the overall outcome, taking the hemorrhagic worsenings into account, was quite favorable.

The design of the European Study (ECAS) was similar to that of the NIH Trial, but it had somewhat different results. The two studies are contrasted in Fig. 6. It should be noted that the time window for treatment was longer (six vs three hours) and the dose higher in the ECAS Study than in the NIH Study. In addition to these rather obvious differences there may be other differences that explain the higher hemorrhage rate in the treated group. The ECAS Study used strict CT exclusion criteria, eliminating patients that had any indication of early infarct on CT in addition to those with hemorrhagic change. The CT criteria, however, must have been difficult to follow, because there was a 19% protocol violation in the study. The CT criteria utilized in the NIH Study was absence of hemorrhage. Several other studies using streptokinase and longer treatment windows have been terminated due to high hemorrhage rates (Table 2), so agents and time windows other than those used in the NIH Study cannot currently be recommended. In addition, trials are underway to assess the use of thrombolysis in angiographically delivered doses. Use of angiography has the advantage of defining an occluded vessel before thrombolysis is used and can give additional information about the pathophysiology of the ischemic process. However, angiography is time-consuming, carries some additional risk, and based on the NIH Trial results, is not necessary to a successful clinical outcome.

Appropriate blood pressure management in any acute stroke is vital, particularly in patients with acute strokes receiving thrombolytic therapy. Most patients with acute ischemic stroke will have elevated blood pressure and impaired autoregulation in the area of infarction. Overly aggressive

FIGURE 7
Stroke Acute Blood Pressure Management



Avoid labetalol with asthma, cardiac failure, cardiac conduction disorders

TABLE 4
Management Scheme for Bleeding Complications

- A. Begin volume replacement with normal saline or D5 1/2 normal saline.
- B. Send blood for type and cross match, PT, and PTT; get reptilase time if patient is receiving heparin.
- C. If PT, PTT, and bleeding time are normal attempt to avoid transfusion.
- D. Blood loss that cannot be adequately controlled, as well as any CNS bleeding, should be treated aggressively:
 1. Cryoprecipitate 10 units given STAT; check fibrinogen after infusion and if less than 1 gm/L repeat dose.
 2. Continue crystalloid to maintain blood pressure and give packed red cells to maintain hematocrit above 30.
 3. 2 units of fresh frozen plasma, STAT.
 4. 10 units of platelets, STAT.
 5. If the patient continues to bleed after the above:
 - a. Check the bleeding time.
 - b. If bleeding time is less than nine minutes, infuse antifibrinolytic agent (5 gm loading dose then 1 gm/hr of epsilon aminocaproic acid).
 - c. If bleeding time is greater than nine minutes, repeat 10 units of platelets followed by antifibrinolytic therapy

treatment of blood pressure may aggravate ischemia and lead to enlarged areas of infarction, but failure to treat very high levels of blood pressure in patients who have received thrombolytic therapy may increase the chance of hemorrhagic conversion of the infarct. It is suggested that only high levels of blood pressure be treated, since blood pressures tend to decrease spontaneously over the first few days after stroke even without therapy. One suggested algorithm for blood pressure management in acute ischemic stroke is given in Fig. 7. Additional guidelines of currently accepted therapy for ischemic stroke are available from American Heart Association Stroke Council Guidelines for Ischemic Stroke Treatment and can be obtained from the American Heart Association, Tennessee Affiliate.⁹

Patients receiving thrombolytic therapy must be managed in an intensive care setting with staff experienced in monitoring for neurologic deterioration. Any neurologic deterioration should lead to neurologic reevaluation, a follow-up CT scan, and institution of treatment should hemorrhagic complications arise. A suggested algorithm for hemorrhage management is given in Table 4. Availability of appropriate specialty coverage (neurologic, neurosurgical, and hematologic) knowledgeable in handling such complications would seem appropriate for institutions contemplating use of this agent for stroke.

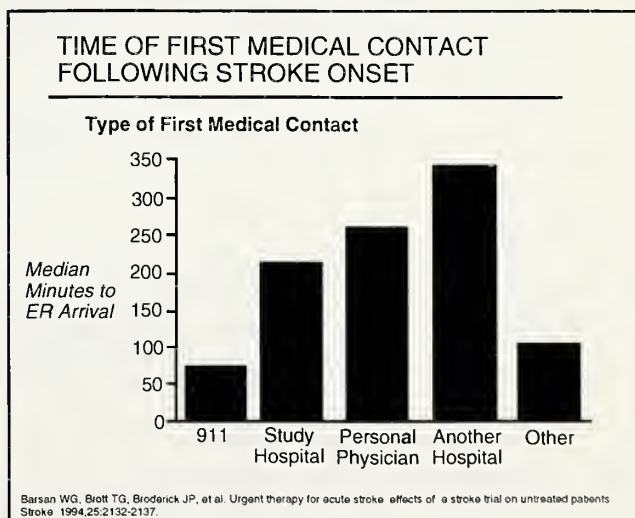
Because time is a critical factor in treatment, institutions planning to introduce this therapy should plan to have a

community education program to alert the population to the signs and symptoms of stroke and encourage quick response. It is clear that the response is fastest when persons call 911 rather than their physician or hospital (Fig. 8), so that some modifications of current patterns of handling patients with acute stroke may be needed. A training program for paramedic ambulance crews and emergency room personnel is necessary so that there can be a rapid response to patients. Mock runs similar to disaster alerts would help keep personnel crisp in their response. Stroke teams consisting of neurologists or neurosurgeons knowledgeable in acute stroke intervention and *quickly available* to respond both to the acute stroke and to complications in patients treated with thrombolysis have been or are being developed in some centers and will likely lead to improved outcomes with fewer complications. Unfortunately, these teams may slightly alter some existing referral patterns and bypass temporarily gatekeepers in managed care organizations, but the improved outcome in a costly and devastating condition will likely convince managed care organizations of the utility of such an approach.

Future Directions

A number of questions remain to be answered as this therapy is better defined. Is there a subgroup of patients that can be identified with a lower risk of hemorrhage? The CT findings before treatment, initial stroke severity, or some hematologic parameter may be useful to predict hemorrhagic conversion. Is the three-hour window too exclusive, and can some patients be treated beyond three hours? Could cerebral protective agents extend the window?¹⁰ Are there subgroups of patients with a better prognosis? Differences in stroke subtype, differences in collateral circulation, or differences in

FIGURE 8



risk factor demographics could be useful predictors. It should be remembered that many thousands of patients were treated in controlled trials of myocardial infarction before benefit was shown, and work continues to define the best agents and treatment protocols. Treatment of stroke with thrombolysis must therefore be considered to be in its infancy. It is hoped that cerebral protective agents will be developed that can further improve outcome by biochemically salvaging cerebral tissue and/or prolonging the window of opportunity for the use of thrombolysis in cerebral ischemia. One could envision the combined use of cerebral protective agents and thrombolysis in a time window that could be more inclusive of the large number of stroke patients currently not candidates for thrombolysis because of the length of time to initiation of treatment. □

References*

1. Pessin M, del Zoppo G, Estol C: Review: Thrombolytic agents in the treatment of stroke. *Clin Neuropharmacol* 13:271-289, 1990.
2. Astrup J, Siesjö B, Symon L: Thresholds for cerebral ischemia—the ischemic penumbra. *Stroke* 12:723-725, 1981.
3. Morawetz R, DeGirolami U, et al: Cerebral blood flow determined by hydrogen clearance during middle cerebral artery occlusion in unanesthetized monkeys. *J Neurosurg* 54:773-782, 1981.
4. Jones T, Morawetz R, et al: Thresholds of focal cerebral ischemia in awake monkeys. *Stroke* 9:143-149, 1978.
5. Zivin J, Lyden P, et al: Tissue plasminogen activator. Reduction of neurologic damage after experimental embolic stroke. *Arch Neurol* 45:387-391, 1988.
6. NIH t-PA Study Group: Tissue plasminogen activator for acute ischemic stroke. *N Engl J Med* 333:1581-1587, 1995.
7. Hacke W, Kaste M, et al: Intravenous thrombolysis with recombinant tissue plasminogen activator for acute hemispheric stroke. The European Cooperative Acute Stroke Study (ECASS). *JAMA* 274:1017-1025, 1995.
8. Lyden P, Zivin J: Hemorrhagic transformation after cerebral ischemia: mechanisms and incidence. *Cerebrovascular and Brain Metabolism Reviews* 5:1-16, 1993.
9. American Heart Association Special Writing Group of the Stroke Council. Guidelines for the Management of Patients With Acute Ischemic Stroke. Dallas, American Heart Association, 1994.
10. Zivin J, Mazzarella V: Tissue plasminogen activator plus glutamate antagonist improves outcome after embolic stroke. *Arch Neurol* 48:1235-1238, 1991.

*The complete reference list is available from the author upon request.

Department of Health Report . . .

(Continued from page 450)

hospitals for consultation, and on-site in-service training, especially for those hospitals with high rates of unsatisfactory specimens and missing information on the laboratory slip. A training video on collection technique is also available to hospitals, and to private and public providers such as health departments. Some hospitals have a designated "newborn screening contact/coordinator" and have established

quality control programs to reduce the rate of unsatisfactory specimens and the number of laboratory forms with missing information. TDH recommends that all hospitals designate a staff member as coordinator to perform this function.

Questions regarding newborn screening or follow-up may be addressed to the Newborn Screening Coordinator at the State Laboratory (615) 262-6304. □

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INDEX TO VOLUME 89

Tennessee Medicine

PAGES BY ISSUE

January	1-36	May	145-180	September	309-348
February	37-72	June	181-224	October	349-388
March	73-108	July	225-268	November	389-428
April	109-144	August	269-308	December	429-468

INDEX OF AUTHORS

Atkinson, Karen	16	Hall, Joe	282	Overholt, Lyn	171
Avery, J Kelley	19, 51, 87, 127, 161, 244, 286, 322, 363, 382, 400, 440	Hall, John R	413	Overlock, Marc E	403
Bahan, Irish	365, 438	Hall, Mary F	79	Patel, Deepa	294
Bailey, James E	122	Hamdy, Ronald C	43	Patton, Joe H Jr	291
Barker, Donald E	117	Hamp, Frida	462	Pearson, Cornelia M	299
Bass, John G	335	Hanumanthu, Sai	47	Pearson, Richard M	149, 185, 229, 273, 313, 353, 395, 433
Batson, James H	115	Harvill, Leo M	7	Pharris Larry J	48
Beecham, Valerie F	43	Holmes, Marilyn	415	Phillips, Joseph B	50
Beyth, Rebecca J	296	Hornsby, Robert P	90	Promes, John T	13
Bond, Annelle	138, 257	Hourany, Joseph	247	Quimby, Charles W Jr	381
Bowers, Robert E	21, 59, 93, 131	Humphrey, Betsy	153	Robertson, Kevalyn	63
Burkhart, John H	137	Ikard, Robert W	164	Rosenfeld, Jo Ann	407
Byrd, Ryland P Jr	41, 115, 247, 328, 369	Johnston, Mary E	54	Roy, Thomas M	7, 41, 115, 247, 369
Cancellaro, Louis A	284	Jolley, Bill	330	Samandari, Taraz	417
Caprio, Francis J	15, 48, 252, 294	Joyner, Suellen	18	Sewell, Tim	155, 241, 319, 359, 442
Chang, Cyril F	158	Khan, Ghazali A	447	Shorr, Ronald I	296
Chapman, G T	249	Kirshner, Howard S	374, 410	Smalley, David L	79
Clapp, Roger C	167	Kirtane, Mohan V	191	Smith, Brian D	85, 120, 417
Clark, Vanessa	66	Knabb, Linda	381	Somberg, Lewis B	117, 372
Craft, Phillip R	372	Krishna, Eechampati	5	Spickard, Anderson III	338
Crawford, Paul	413	Larkin, Peggy	302	Stevens, Michael V	79
Croce, Martin A	81, 291	Lee, Larry H	421	Subramanyamm, Arumughakumari B	5
Crook, William G	341	Lewis, Frances I	447	Talmadge, James B	171
Doster, Jean	83, 378	Lewis, James V	167, 413	Testerman, George M	167
Earnest, Rick	121	Light, Judy	420	Thomas, Anne	166
Eddy, Virginia A	335	Lowery, Robbie	81	Thomison, John B	22, 23, 60, 62, 63, 94, 95, 96, 132, 134, 150, 151, 152, 187, 188, 189, 231, 232, 233, 275, 276, 278, 315, 316, 355, 356, 397, 435, 436
Edmondson, W D	85	Luckmann, Kenneth F	24	Tilley, Steve	166
Einhaus, Stephanie L	81	Lukeman, Robert W	328	Turner, Dorothy J	126
Emerson, Trey	77	Lyden, Sean P	291	Udoji, Walter C	113
Enderson, Blaine L	45	Manitzas, Nick D	45	Vegors, Sue	381
Engel, Jeannine Z P	47, 84, 338, 376	Mathai, Matthew	41, 328	Watridge, Clarence B	81
Fabian, Thaddeus S	372	Mathew, M K	328	Wattad, Ahmad A	5
Fabian, Timothy C	81	Mathews, Jeffrey A	117	Weber, Laurie	84
Fields, Cheryl L	369	Meeks, Edwin A	24	Williford, Gloria	100
Fleming, June	126	Mehta, Ashok V	5	Womack, Judith M	169
Fleshood, H Lee	450	Mehta, Jay B	7, 369	Womeodu, Robin J	122
Frame, Scott B	249	Melton, Sherry M	291	Woodall, Annabel	31
Gaines, Kenneth	451	Micklewright, Melinda	43	Woody, Jonathan D	372
Gallemore, Gail	289	Miller, Russ	235, 399	Worley, Kim	289
Garrigan, Liz	239	Mirvis, David M	158	Yarbrough, Mary	415
Garris, G W	120	Moore, Sharon W	43	Zahorik, P M	407
Gaw, David A	77	Moore, William L	254	Zenker, Mark A	121
Gonzales, Robert J	403	Morgan, Mary	341		
Hagmann, Catherine E	56	Morris, John A Jr	13		
		Mukkamala, Raghu	115		
		Newman, John	166		
		Nunn, Craig R	335		

INDEX OF SUBJECTS

Abbreviations: "ed" for editorial; "(*)" for original contribution; "le" for letters to the editor; "pp" for president's page; "si" for special item; "TMA-96" for TMA 1996 annual meeting.

Acquired Immunodeficiency Syndrome (AIDS)	
ten-year summary of human immunodeficiency virus serology in West Tennessee (*)	79
Alliance/Auxiliary Page	(See TMA Alliance/Auxiliary)
American Medical Association	
a special tribute (to retiring AMA delegates)	58
a tribute to those who serve (pp)	59
AMA fights for physician antitrust relief—Department of Justice and FTC redefine antitrust rules	442
federation mediation meditation—or hesitation? trepidation? (ed)	315
overhauling the federation of medicine	319
ramblings from an AMA ex-delegate (ed)	60
Announcements	25, 65, 99
Ballard, Thomas K Jr, celebration of a life (ed)	316
Board of Medical Examiners	(See Tennessee State BME)
Cancer	
a need to study utilization of in-hospital volunteer manpower for hospitalized adult cancer patients (si)	56
cardiac tamponade as the initial presentation of bronchioloalveolar cell carcinoma (*)	247
thyroglossal duct cyst mass with Hashimoto's disease and non-Hodgkin's lymphoma (*)	113
Capitation	(See Managed Care)
Cardiovascular Disease	
cardiac tamponade as the initial presentation of bronchioloalveolar cell carcinoma (*)	247
catheter-associated central venous thrombosis (*)	328
Cat Scratch Disease , presenting as multifocal osteitis (*)	289
Catheters , and central venous thrombosis (*)	328
Communication	
campaigning in cyberspace	402
HMOs—the latest revisitation (ed)	397
on providing and consuming (ed)	231
patient information on the internet	365
teaming up with UT football—TMA's 1996 radio campaign	399
Continuing Medical Education Opportunities	30, 67, 102, 174, 218, 259, 303, 343, 384, 422, 463
Costs, Health Care	(See Managed Care & Medical Practice)
Disability	(See Impairment)
Doctors' Day	
doctors' day (ed)	62
remembering our physicians	66
Down's Syndrome	
acute renal failure associated with use of angiotensin converting enzyme inhibitor—a report of two children with Down's syndrome (*)	5
Drugs	
a potentially fatal drug reaction	294
avoiding problems prescribing to older patients	296
management of prescribing with emphasis on addictive or dependence-producing drugs (si)	173
when Goody's Powder is not so good (*)	43
Editorials	
a new look	150
an HMO Christmas story	62
celebration of a life: Tommy Ballard, R.I.P.	316
doctors' day	62
eldercare	276
federation mediation meditation—or hesitation? trepidation?	315
flotsam and jetsam	132
for each new sunrise . . .	436
forget, hell!!! an apology, sort of, or rather, an . . . er explanation	23
foxy in the henhouse	151
hello, choir! are you listening?	188
HMOs—the latest revisitation	397
housekeeping matters	95
IMPACT!!!	355
impairment ratings	152
med school revisited: 1941 to '44—and so on to 1996 and beyond	356
mellowing for 1996	22
on providing and consuming	231
partners in politics	23
ramblings from an AMA ex-delegate	60
safety first—mostly	278
scouting for zebras	435
serendipity knocks but once—maybe	96
some happy thoughts	189
stroke	355
telemedicine	275
Tennessee bicentennial	187
TMA Student Loan Fund: an appreciation	134
Thanksgiving	397
the doctor's obligation	94
the once and future annual meeting	233
the saga of sunny: a bicentennial tail for the fourth	232
to be or not to be . . . that was just one of the questions	235
when the board comes a'callin'	63
Education, Medical	
medical school revisited: 1941 to '44—and so on to 1996 and beyond (ed)	356
students: fulfilling the dream	359
where did all the specialties go? managed care trends steer tomorrow's MDs into primary care slots	241
Ethics, Medical	(See also Loss Prevention)
crossing a patient's sexual boundaries	403
Geriatric Medicine	
avoiding problems prescribing to older patients	296
care of the geriatric trauma patient	291
eldercare (ed)	276
Health Care	(See Health Dept & Medical Practice)
Health Care Reform	(See Managed Care & Medical Practice)
Health Department Report	
breastfeeding promotion—a community consortium approach	126
child fatality review in Tennessee	18
improving emergency medical care for pediatric patients	50
newborn screening in Tennessee	450
office of rural health: forging the future of rural health recruitment and retention	330
post-exposure immunoprophylaxis and chemoprophylaxis for communicable diseases	254
preventing childhood lead poisoning in Tennessee	415
preventing traumatic brain injury	378
project TEACH in the school system	169
Tennessee's traumatic brain injury program	83
tobacco use: Tennessee youths at risk	299
Hematology	
a veteran with eosinophilia	15
History	
forget, hell!!! an apology, sort of, or rather, an . . . er explanation (ed)	23
Tennessee bicentennial (ed)	187
Thanksgiving	397
HIV Infection	(See AIDS)
IMPACT	(See Political Action)
Impairment	
disability evaluations (le)	171
impairment ratings (ed)	152
the doctor's obligation (ed)	94
use and misuse of the AMA Guides in assessing impairment (*)	77

In Memoriam	24, 64, 98, 134, 171, 217, 257, 302, 342, 383, 421, 462
Infectious Disease	(See also AIDS & Health Dept)
a case of penicillin-resistant pneumococcal meningitis	120
an unavoidable complication of septic arthritis	16
cat scratch disease, presenting as multifocal osteitis (*)	289
extrapulmonary tuberculosis in Tennessee: lessons from the last decade (*)	7
post-exposure immunoprophylaxis and chemoprophylaxis for communicable diseases	254
pulmonary abscess due to <i>Corynebacterium striatum</i> (*)	115
Insurance	(See Impairment & Medical Practice)
Letters to the Editor	
disability evaluations	171
governor's office	24
illiteracy	63
loss prevention	381
managed care	24
there <i>are</i> better ways to help these children	341
tobacco abuse	421
Loss Prevention Case of the Month	
a young woman fainted	87
another pediatric nightmare	19
complication during arthroscopy	161
did socioeconomic factors influence clinical decisions	440
difficult diagnosis	244
maternal/fetal death	51
negligence in a good practice	399
postoperative delay	363
postpartum back pain, so what!	322
outcomes can be very unexpected	127
who/where is my doctor?	286
Malpractice	(See Loss Prevention)
Managed Care	(See also Medical Practice)
a paradigm for healing (pp)	185
an HMO Christmas story (ed)	62
flotsam and jetsam (ed)	132
grading TennCare	158
hello, choir! are you listening (ed)	188
HMO preparedness—know your practice inside and out	438
HMOs—the latest revisitation (ed)	397
it's time to take off the gag—TMA takes progressive action to head off managed care gag rules	153
managed care: are restrictive provider panels out and capitation in?	191
prevention in managed care: obstacles and opportunities	122
teaming up with UT football—TMA's 1996 radio campaign	399
TennCare BHOs—partners program startup mirrors TennCare; mental health patients lumped into two plans	239
where did all the specialties go? managed care trends steer tomorrow's MDs into primary care slots	241
Meckel's Diverticulum , diagnosis by computerized tomography (*)	164
Medicaid-Medicare	(See Medical Practice)
Medical Practice	(See also Loss Prevention, Managed Care)
building for the future—Memphis integrated delivery systems may provide a glimpse of the future for Tennessee doctors	155
comparison of female and male graduates of southern appalachian family practice residencies (*)	407
do you have one? (pp)	93
energy enough (pp)	313
foxy in the henhouse (ed)	151
heri, hodie, crass . . . yesterday, today, and tomorrow	284
HMO preparedness—know your practice inside and out	438
patient information on the internet	365
safety first—mostly (ed)	278
scouting for zebras (ed)	435
stand fast (pp)	433
strength in diversity (pp)	21
strong as oaks (pp)	149
telemedicine (ed)	275
telemedicine—physicians using latest technology to help patients	282

the road ahead (pp)	131
where did all the specialties go? managed care trends steer tomorrow's MDs into primary care slots	241
Medicolegal	(See also Loss Prevention)
AMA fights for physician antitrust relief—Department of Justice and FTC redefine antitrust rules	442
crossing a patient's sexual boundaries	403
foxy in the henhouse (ed)	151
it's time to take off the gag—TMA takes progressive action to head off managed care gag rules	153
Mental Health	
on providing and consuming (ed)	231
TennCare BHOs—partners program startup mirrors TennCare; mental health patients lumped into two plans	239
there <i>are</i> better ways to help these children (1c)	341
New Members	25, 64, 98, 135, 171, 217, 257, 302, 342, 383, 421, 462
Nephrology	
acute renal failure associated with use of angiotensin converting enzyme inhibitor—a report of two children with Down's syndrome (*)	5
Neurology	
preventing traumatic brain injury	378
Tennessee's traumatic brain injury program	83
use of hypertonic saline for the treatment of increased intracranial pressure	81
Obstetrics/Gynecology	
management of the pregnant patient with acute spinal cord injury	335
Organized Medicine	(See AMA, Medical Practice)
Pathology	
thyroglossal duct cyst mass with Hashimoto's disease and non-Hodgkin's lymphoma (*)	113
Weber-Christian disease, recognizing (*)	447
Pearson, Richard M —the new president	129
Pediatrics	(See also Health Dept)
acute renal failure associated with use of angiotensin converting enzyme inhibitor—a report of two children with Down's syndrome (*)	5
Personal News	25, 64, 98, 134, 172, 217, 257, 303, 384, 422
Physician's Recognition Award Recipients	26, 64, 98, 135 172, 218, 259, 302, 342, 383, 421, 463
Political Action	
campaigning in cyberspace	402
dollars can make an impact	381
IMPACT!!! (ed)	355
partners in politics (ed)	23
partners in politics	31
'96 election—every vote counts	324
President's Comments	
a paradigm for healing	185
a tribute to those who serve	59
at the front	229
do you have one?	93
emperors and empires	353
energy enough	313
first names	273
stand fast	433
strength in diversity	21
strong as oaks	149
thank you	395
the road ahead	131
Preventive Medicine Series	
avoiding problems prescribing to older patients	296
grading TennCare	158
prevention in managed care: obstacles and opportunities	122
Professional Liability Insurance	(See Loss Prevention)
Pulmonary Disease	
cardiac tamponade as the initial presentation of bronchioloalveolar cell carcinoma (*)	247
catheter-associated central venous thrombosis (*)	328
extrapulmonary tuberculosis in Tennessee: lessons from the last decade (*)	7

nutritional status and mortality in respiratory failure caused by tuberculosis (*)	369
posttraumatic pulmonary mass (*)	41
pulmonary abscess due to <i>Corynebacterium striatum</i> (*)	115
Radiology	
Meckel's diverticulum, diagnosis by computerized tomography (*)	164
Reform, Health Care (See Medical Practice)	
Residencies , comparison of female and male graduates of southern appalachian family practice residencies (*)	407
Smoking (See Tobacco)	
Special Features	
a need to study utilization of in-hospital volunteer manpower or hospitalized adult cancer patients	56
a serendipitous peek at tobacco	90
a special tribute (retiring AMA delegates)	58
a tribute to Bill Wallace	137
management of prescribing with emphasis on addictive or dependence-producing drugs	173
stroke prevention: recommendations	333
when the board comes a'callin'	54
Stroke (See also Stroke Prevention Series)	
stroke (ed)	355
stroke prevention: recommendations (si)	333
Stroke Prevention Series	
acute stroke intervention	451
medical revolution: the prevention and treatment of stroke, 1996, part 1. stroke prevention and carotid endarterectomy	374
medical revolution: the prevention and treatment of stroke, 1996, part 2. medical prevention of stroke and acute stroke therapy	410
Surgery (See Trauma Rounds)	
Telemedicine	
telemedicine (ed)	275
telemedicine—physicians using latest technology to help patients	282
TennCare (See also Managed Care, Medical Practice)	
grading TennCare	158
TennCare BHOs—partners program startup mirrors TennCare; mental health patients lumped into two plans	239
Tennessee Medical Association (See also Tennessee Medicine)	
a tribute to Bill Wallace	137
community service awards, 1996	212
component society officers, 1996-1997	262
distinguished service awards, 1996	211
highlights of the board of trustees meetings	
October 7-8, 1995	28
January 13-14, 1996	136
April 11 and 14, 1996	260
July 13-14, 1996	382
HMOs—the latest revisitation (ed)	397
house of delegates, composition (TMA-96)	216
house of delegates, index to proceedings (TMA-96)	193
house of delegates, proceedings (TMA-96)	194
housekeeping matters (ed)	95
leadership, 1996-1997	261
outstanding physician of the year, 1996	211
reports of officers (TMA-96)	206
TMA student loan fund: an appreciation (ed)	134
teaming up with UT football—TMA's 1996 radio campaign	399
the new president—Richard M. Pearson, MD	129
the once and future annual meeting (ed)	233
TMA Alliance/Auxiliary	
a year of firsts	171
accomplishments of a healthy organization	341
AMA-ERF	420
dollars can make an impact	381
goals 1996—why we matter	381
handrails for membership	302
jump start '96	138
partners in politics	31
remembering our physicians	66
TMAA sixty-eighth annual meeting	100
yes, we can!	257

youth health workshop '96	462
TMA Journal (See Tennessee Medicine)	
Tennessee Medicine	
a new look (ed)	150
housekeeping matters (ed)	95
index to volume 89	459
mellowing for 1996 (ed)	22
to be or not to be . . . that was just one of the questions (ed)	235
Tennessee State BME	
when the board comes a'callin' (ed)	63
when the board comes a'callin' (si)	54
Tennessee State BME Meeting Minutes	
October 1995	26
November 1995	65
January 1996	135
February 1996	172
March 1996	218
April 1996	258
May 1996	303
June 1996	342
September 1996	463
Thyroid	
thyroglossal duct cyst mass with Hashimoto's disease and non-Hodgkin's lymphoma (*)	113
Tobacco	
a serendipitous peek at tobacco (si)	90
green tobacco sickness (bradycardia in a young farmer)	84
serendipity knocks but once—maybe (ed)	96
tobacco abuse (le)	421
tobacco use: Tennessee youths at risk	299
Tuberculosis (See Pulmonary Disease)	
Trauma (See also Trauma Rounds)	
posttraumatic pulmonary mass (*)	41
Trauma Rounds	
an abdominal hernia secondary to blunt trauma	167
care of the geriatric trauma patient	291
diaphragmatic rupture	117
management of the pregnant patient with acute spinal cord injury	335
nonoperative management of a blunt pancreatic injury	413
open pelvic fracture: delayed diagnosis	13
penetrating wound to the shoulder: a case report that illustrates the need for a multisystem approach to injury	45
repair of penetrating cardiac injury using skin staples	249
traumatic pseudocyst of the spleen	372
use of hypertonic saline for the treatment of increased intracranial pressure	81
Vanderbilt Morning Report	
a case of penicillin-resistant pneumococcal meningitis	120
a diabetic man with left shoulder pain	252
a potentially fatal drug reaction	294
a veteran with eosinophilia	15
an unavoidable complication of septic arthritis	16
antiphospholipid and anticentromere antibodies occurring together in a patient with pulmonary hypertension	166
bilateral adrenal hemorrhage and acute Addisonian crisis—a complication of antiphospholipid syndrome	120
epigastric pain unrelieved by omeprazole	75
green tobacco sickness (bradycardia in a young farmer)	84
low back pain with progressive weakness: a case of cauda equina syndrome from lumbar disc herniation	338
neck pain in a young woman	48
progressive somnolence and confusion in a patient with hereditary hemorrhagic telangiectasias	417
shortness of breath and chest pain in a patient with scleroderma	376
the great imposter	47
Volunteers	
a need to study utilization of in-hospital volunteer manpower for hospitalized adult cancer patients (si)	56
Weber-Christian Disease (*)	447
Wallace, William V (Bill)	
a tribute to Bill Wallace	137
TMA student loan fund: an appreciation (cd)	134

TMA Alliance Report

Youth Health Workshop '96

It is with great pleasure and honor that we, the Henry-Carroll County Medical Society Alliance, share this report on our recent Health Promotion Project. Our Youth Health Workshop held this past September was a tremendous success and real team effort!

Along with the generous grant received from the TMA and TMAA of \$1,500, our Alliance was privileged to help sponsor the talented group of young performers, The All-American Singers.

With their assembly program entitled "Choices," this highly professional group of 24 performers and technicians between the ages of 18 and 22 assisted us with our theme for this year "choices our teens are faced with." The All-American Singers gave a 50-minute presentation designed to present positive choice making principles. The featured "5 Credos to Live By" asks students to order their lives around basic principles that will benefit each of them and their communities. These credos deal specifically with attitude, integrity, patriotism, self-esteem, and responsibility.

During two performances for the youth of Huntingdon an estimated 800 students were reached, and with three additional performances in Paris, an estimated 2,400 county and city students were reached. Such was our desire for more of our youth to hear this message that we helped co-sponsor yet another presentation for the entire high school body in Paris, an estimated 1,400 students!

Our success was made even greater by having distinguished guests—from the TMA the CEO Mr. Don Alexander, and our TMAA president-elect Mrs. Nancy Hines—bring greetings and words of encouragement. Our sincere thanks and great appreciation to all who made this possible.

Frida Hamp, President
Henry-Carroll County
Medical Society Alliance

New Members

Tennessee Medicine takes this opportunity to welcome these new members to the Tennessee Medical Association.

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY

Krystyna T. Alimurka, MD, Chattanooga
Joseph Bird Jr., MD, Chattanooga
Mark Carpenter, MD, South Pittsburg
Charles A. Crump Jr., MD, Chattanooga
Ian Hamilton Jr., MD, Chattanooga
Mark E. Heinsohn, MD, Signal Mountain
Stephen Humphreys, MD, Chattanooga
George H. Jackson, MD, Chattanooga
William Lanting, MD, Chattanooga

Gary Mason, MD, Chattanooga
Monte Masten, MD, Chattanooga
Robert Mastey, MD, Chattanooga
Kathryn McMinn, MD, Chattanooga
John Nelson, MD, Fort Oglethorpe GA
Glenn A. Newman, MD, Hixson
Tin M. Oo, MD, Chattanooga
Henry K. Paik, MD, Chattanooga
Bernard L. Parham, MD, Chattanooga
Larry Schlabach, MD, Chattanooga
Angela Smith-Slack, MD, Chattanooga
Lee Strauss, MD, Chattanooga
Cleveland Thompson IV, MD, Chattanooga
Barbara VanDerWerken, MD, Chattanooga
Jeffrey D. Visser, MD, Chattanooga

KNOXVILLE ACADEMY OF MEDICINE

Laykoon T. Huang, MD, Knoxville
Mark D. Turner, MD, Knoxville

LAKEWAY MEDICAL SOCIETY

Peter M. Sutherland, MD, Morristown

MAURY COUNTY MEDICAL SOCIETY

James C. Couch III, MD, Mt. Pleasant
David M. Turner, MD, Columbia

NASHVILLE ACADEMY OF MEDICINE

Nelson J. Mangione, MD, Brentwood
Jill D. Rossrucker, MD, Nashville

In Memoriam

William C. Francis, age 67. Died October 13, 1996. Graduate of University of Tennessee College of Medicine. Member of Putnam County Medical Society.

John M. Jackson, age 79. Died September 26, 1996. Graduate of Vanderbilt University School of Medicine. Member of Robertson County Medical Society.

William W. Johnson, age 77. Died September 29, 1996. Graduate of University of Louisville Medical School. Member of Bradley County Medical Society.

William Franklin Outlan, age 75. Died October 4, 1996. Graduate of University of Tennessee College of Medicine. Member of Memphis-Shelby County Medical Society.

Richard F. Stappenbeck, age 79. Died September 17, 1996. Graduate of University of Nebraska College of Medicine. Member of Chattanooga-Hamilton County Medical Society.

Parks W. Walker Jr., age 70. Died October 2, 1996. Graduate of University of Tennessee College of Medicine. Member of Memphis-Shelby County Medical Society.

Board of Medical Examiners

Minutes - September, 1996

Name: Mark Josovitz, MD (Middleton)

Violation: Unprofessional, dishonorable, or unethical conduct; substance abuse; engaging in the practice of medicine when mentally or physically unable to safely do so.

Action: Per agreed order, license suspended for one year, six months of suspension stayed; license to be placed on probation for an additional five years; must maintain advocacy of Impaired Physician Program during probation.

Name: Steven R. Taraszka, MD (Atlanta, GA)

Violation: Action taken in another state.

Action: Per agreed order, license suspended indefinitely; must appear personally before Board to seek lifting of suspension; must obtain advocacy of Physicians' Assistance Program.

Name: William Joseph Willems, MD (Bluefield, WV)

Violation: Action taken in another state.

Action: License revoked.

AMA Physician Recognition Awards

The following TMA members qualified for the AMA Physician's Recognition Award during September, 1996. This list, supplied by the AMA, does not include members who reside in other states.

Physicians can receive the PRA certificate valid for one, two, or three years. For the one-year award, physicians report 50 hours of continuing medical education, including 20 hours of Category 1; for the two-year award, physicians report 100 hours of CME, including 40 hours of Category 1; for the three-year award, physicians report 150 hours of CME, 60 of which are Category 1. Each application for the PRA must also verify participation in Category 2 CME activities.

Jerome H. Abramson, MD, Chattanooga

Rex A. Amonette, MD, Memphis

Kimberly T. Breeden, MD, Athens

Herbert D. Ladley, MD, Kingsport

John C. Rodgers Jr., MD, Knoxville

Christopher W. Sholes, MD, Johnson City

CME Opportunities

TMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) as a sponsor of continuing medical education for physicians. As an accredited sponsor, TMA is authorized to designate certain CME activities for credit in the AMA Physician's Recognition Award Program.

TMA is recognized by ACCME as the accreditor of institutions in Tennessee conducting intrastate CME programs. Any organization conducting such programs may apply to TMA for accreditation as a sponsor of CME.

Inquiries regarding application for accreditation as a sponsor of CME should be made in writing to: CME Department, Tennessee Medical Association, PO Box 120909, Nashville, TN 37212-0909.

Vanderbilt University Medical Center

Clinical Training Program

The doctor and faculty plan an individualized program to meet the physician's practice needs. This may include contact with patients, participation in clinical rounds and diagnostic procedures, interaction with faculty and housestaff, access to the Medical Center Library and other learning resources, and other benefits of a preceptorship. AMA/PRA Category 1 credit is provided for each hour of participation. Physicians *must* be licensed and be in active practice with evidence of liability coverage.

For information contact Division of CME, Vanderbilt University School of Medicine, D-8211 MCN, Nashville, TN 37232, Tel. (615) 322-4030.

University of Tennessee

Continuing Education Schedule

Memphis

- Jan. 9-11 High Risk Perinatal Seminar
- Feb. 17-20 Update in Obstetrics & Gynecology—Grand Caymen Island
- Feb. 23-28 Clinical Medicine—Kauai, Hawaii
- March 6-8 Symposium on Critical Care & Emergency Medicine—Hot Springs, Ark.
- March 8-15 Current Issues in OB/GYN—Snowmass Village, Colo.
- March 16-22 30th Review Course for the Family Physician
- June 6-7 1997 General Surgery Update
- Aug. 4-9 Contemporary Issues in Ob/Gyn—Destin, Fla.
- Sept. 25-26 28th Memphis Conference on the Newborn
- Oct. 25-28 International Conference on Fetal and Neonatal Measurements

Knoxville

- April 23-25 20th Family Practice Update & Review—Gatlinburg
- June 6-10 13th Alzheimer's Disease Symposium—Gatlinburg
- June 12-14 42nd Great Smoky Mountains Pediatric Seminar—Gatlinburg

Chattanooga

- Feb. 23-26 Clinical Medicine—Kauai, Hawaii
- March 7-8 Allergy & Immunology
- March 20-21 Pediatrics
- June 18-21 Family Medicine
- Oct. 16-17 Aging Patient
- Dec. 4-5 Internal Medicine Update

For information contact Mrs. Jean Bryan, Office of CME, University of Tennessee, 800 Madison Ave., Memphis, TN 38163, Tel. (901) 448-5547.

East Tennessee State University

Continuing Education Schedule

- April 18-19 Advanced Life Support in Obstetrics
- Aug. 2-3 Southwest Virginia Pediatric Conference
- Nov. 1-2 Pumpkin Patch Pediatric Conference
- Nov. 2 Women's Health Conference

For information contact Office of Continuing Medical Education, James H. Quillen College of Medicine, East Tennessee State University, PO Box 70559, Johnson City, TN 37614, Tel. (423) 929-4341.

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Phone: 615-322-2513 Fax: 615-343-2293
owenexec@ctrvax.vanderbilt.edu
<http://www.vanderbilt.edu/Owen>

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McMinnville — Columbia River Park Hospital is a newly constructed facility with an annual patient volume of 17,000. It is located within an hour and a half of Nashville and Chattanooga in the foothills of the scenic Cumberland Plateau.

Clinical Opportunities

Maryville — Blount Memorial Hospital has an approximate annual patient volume in excess of 40,000 with physician assistant double coverage provided 12-hours per day. Located in the foothills of the Smokies, Maryville is only 30 minutes from Knoxville.

Sevierville — Fort Sanders Sevier has PA double coverage and a PA staffed fast-track. The facility is located 10 minutes from the outlets of Pigeon Forge and the skiing in Gatlinburg, and it is only 40 minutes from downtown Knoxville.

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PUBLIC HEALTH PHYSICIAN POSITIONS

The Tennessee Department of Health is recruiting physicians for two District Health Officer positions for multicounty areas in Middle Tennessee. Salary in high-70s to low-80s. Positions provide direct patient care including adult and children's ambulatory care, preventive clinical services, family planning, prenatal care, and consultation for nurse practitioners. Must have an MD or DO degree, post medical education, and clinical experience in a primary care specialty totaling at least three years, and Tennessee license.

Contact Ruth M. Hagstrom, MD, 426 5th Ave. North, Nashville, TN 37247-5001. Phone (615) 532-2431. TDH is an equal opportunity, equal access, affirmative action employer.

RURAL AREAS SEEKING PRIMARY CARE PHYSICIANS

Family Healthcare Medical Centers, which are located in the scenic mountains of Northeast Tennessee, are accepting CVs from physicians. These health care facilities offer competitive wages and superior benefits. This consists of 401K, mileage reimbursement, paid malpractice insurance, continuing medical education, ten official holidays off with pay, and relocation is available.

If interested in becoming a part of our work team, mail CVs to Ms. Misty Trent, Rural Health Services Consortium, 3825 Hwy. 66 South, Rogersville, TN 37857. Phone: (423) 272-9163, fax: (423) 272-4980, e-mail address rhscmis@planetcc.com. EOE

Supplement to

Tennessee Medicine

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November 1996

STACKS

**New Patient
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**Managed Care
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TENNESSEE
MEDICAL
ASSOCIATION

November 1996

Dear Fellow TMA Members:

We want to draw your attention to the special information contained in this month's *Tennessee Medicine*. Inside you will find a special communication article detailing the TMA's public information campaign on managed care. Our goal is to alert patients and health care decision makers that new health care plans should be scrutinized carefully. Patients are encouraged to talk with their doctor or contact the TMA for more information.

The campaign is multifaceted and includes:

- a radio advertising campaign with spots airing on the 90 stations of the Vol Radio Network, as well as during the prime time newscasts on the 80 stations of the Tennessee Radio Network;
- a full page color display advertisement in the University of Tennessee Football Program;
- brochures for patients;
- a reproducible version of the brochure for personal use by TMA members.

Attached to this letter is the artwork for a reproducible information brochure on managed care. The brochure is written for patients and suggests questions to ask about a plan before making a decision to enroll.

To produce brochures for your patients:

1. Separate the master copy from this letter at the perforation.
2. Take the master to a local print shop (or use your copier if necessary).
3. Have the brochures printed doubled sided and a good heavy stock (80 lb. matte). Consider reproducing on a white stock paper and choose a colored ink rather than black. Green PMS 3435 is a nice choice and is what TMA uses as an official color.
4. Tri-fold and set out in your office or even consider mailing them to your current patients.

Make this information available to your patients. Our marketplace is changing and patients now are wondering exactly who they can trust and talk to about their health care. Be there for them and have the answers.

Sincerely,

Richard M. Pearson, MD
TMA President

Would you let a mechanic file your taxes? Do you want plumbers fixing your car?

Of course not. Then why do so many Tennesseans leave decisions about their health care to graduates of a business school rather than medical school graduates? Today, many patients don't understand that managed health care plans involve sacrifices, such as allowing business people - not you and your physician - to direct your care.

Managed care plans typically restrict a patient's choice of physicians, facilities and services. Often, they cover little or no part of bills issued from non-plan doctors or hospitals. And, the cost-cutting measures that affect patient care many times are established by people who manage medicine from a check book, not a medical book.

As Tennessee physicians, we believe such important decisions should be made by you and your doctor. After all, no one is better qualified to understand and care for your individual needs. We believe it's hazardous to your health to involve anyone else.

Do you know all you should about managed health care plans? The Tennessee Medical Association has created this brochure as a public service to help you better understand managed health care plans and make more informed decisions about your health care.

This brochure is distributed by the Tennessee Medical Association as a public service. TMA is a professional organization of 6,700 medical doctors statewide dedicated to enhancing the effectiveness of Tennessee physicians and protecting the health care interests of patients.

For more information about managed health care plans or services of the Tennessee Medical Association, please ask your physician or call:

Tennessee Medical Association
2301 21st Avenue South
Nashville, Tennessee 37212
(615) 385-2100

Managed health care

Who calls the shots?



TENNESSEE
MEDICAL
ASSOCIATION



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MEDICAL
ASSOCIATION

Managed health care systems involve a network of medical specialists who focus on your primary and preventive care. The anchor of that network is your 'primary care physician,' who is charged with diagnosing and treating you, or referring you to someone within the plan who can. Under a managed health care system, you are entitled to care 24 hours a day, 7 days a week.

However, a number of conditions specific to your individual plan must be met to guarantee full coverage by your insurance carrier. And, usually, the plan manager – not your personal physician – makes the first decision about what care you can receive and what is 'covered,' or paid for.

The following questions give an idea about the many issues surrounding a managed care system. They should help whether you are a benefits manager evaluating your company's plan or simply choosing one for yourself or your family. Read the following questions, then talk with your physician. You might find managed care is not the best plan for you.

1 Does my doctor(s) participate in the plan? If not, can I continue to see my doctor(s)? How much more will it cost me to retain him/her as my physician? How do I change to a doctor who participates in the plan?

2 If I am already seeing a specialist for a pre-existing condition (ie., diabetes or heart disease), can I continue seeing him or her under a new plan?

3 Will I be notified of changes to the plan? How?

4 Will the cost of prescriptions be covered? Can any pharmacy fill that prescription? Are all drugs covered?

5 Does my plan offer coverage for specialty care such as nursing home visits, vision, dental, emergency transportation, durable medical equipment, home health, hospice, physical therapy, etc.?

6 What if I am not pleased with my primary care physician or with a specialist to whom I have been referred? Can I change physicians? If so, how do I go about it?

7 How do I appeal treatment decisions made by the plan?

8 How much will the plan cost me, including premiums, co-payments and other charges?

9 Can I cancel my enrollment in the plan without penalty? At any time, could the plan cancel my enrollment for any reason? If so, what reason?

10 What if I want a second opinion? Will it be covered? Under what circumstances? What do I need to do?

11 Can a woman select an obstetrician/gynecologist as a second primary care physician?

12 Where will I go for care? Does it provide all the services I will need?

13 Am I covered if I require medical attention after hours or on weekends? What if I am out of town and need to see a doctor? Or, if I sustain a life threatening injury and cannot find my primary care physician? Am I covered in these situations?

14 If the answers to question #13 are 'yes,' what are my responsibilities as a patient when pursuing medical attention?

15 Will I be furnished a list of providers? How often will it be updated? Can I call for up-to-the-minute status?

16 Will I be provided the names and phone numbers of contact people within the plan?



